MARKET CONDUCT EXAMINATION REPORT
DATED APRIL, 5 2012

COVERING THE TIME PERIOD OF JANUARY 1, 2009 THROUGH DECEMBER 31, 2009

JOHN ALDEN LIFE INSURANCE COMPANY

501 West Michigan
Milwaukee, WI 53201-3050

NAIC Company Code: 65080
NAIC Group Code: 0019

CONDUCTED BY:

COLORADO DIVISION OF INSURANCE

JOHN ALDEN LIFE INSURANCE COMPANY
501 West Michigan
Milwaukee, WI 53201-3050

MARKET CONDUCT EXAMINATION REPORT
Dated April 5, 2012

Covering the Time Period of January 1, 2009 through December 31, 2009

Examination Performed by:

Division of Insurance Market Conduct Examiner

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And

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TABLE OF CONTENTS

COMPANY PROFILE

The following is taken directly from written documentation provided by John Alden Life Insurance Company and has not been independently verified by the Division of Insurance:

John Alden Life Insurance Company ("John Alden" or "Company") was originally incorporated under the laws of the State of Illinois on January 10, 1961. In 1973, John Alden Life Insurance Company changed names to Gamble Alden Life Insurance Company with the current name being adopted in 1979.

Fortis, Inc., John Alden's ultimate parent company, established Assurant, Incorporated and merged into Assurant, Incorporated as of February 4, 2004. Assurant, Inc. is a publicly traded company.

John Alden was initially licensed and began operation in Colorado on September 6, 1973. During the exam period of January 1, 2009 through December 31, 2009, John Alden was licensed in all states except New York, along with the District of Columbia. During the examination period John Alden Life sold a variety of health benefit products in Colorado including short term individual and group health policies.

The following chart indicates John Alden's market share and premiums written in Colorado for the period under examination:

Premium and Market Share in Colorado as of December 31, 2009*:

Total Written Premium:	$17,579,000
Individual Accident and Health Premium:	$5,151,000
Group Accident and Health Premium:	$12,009,000
Market Share – Total Life, A&H:	.15%
Market Share – Individual A&H:	.47%
Market Share – Group A&H	.24%

*As shown in the 2009 edition of the Colorado Insurance Industry Statistical Report

PURPOSE AND SCOPE OF EXAMINATION

A state market conduct examiner with the Colorado Division of Insurance ("Division"), who was assisted by independent contract examiners, reviewed certain business practices of John Alden. This market conduct examination ("MCE") was conducted in accordance with Colorado insurance laws, §§ 10-1-201, 10-1-203, 10-1-204, 10-1-205 and 10-3-1106, C.R.S., which empower the Commissioner of Insurance ("Commissioner") to examine any entity engaged in the business of insurance in Colorado. All work product developed in producing this report is the sole property of the Division.

The purpose of the examination was to determine John Alden's compliance with Colorado insurance laws related to health insurance business in Colorado. Examination information contained in this report will serve only this purpose, except as provided by law pursuant to §§ 10-1-204 and 10-1-205, C.R.S. The findings and conclusions, including the Final Agency Order arising out of this examination shall be a public record.

The examiners conducted the examination in accordance with procedures developed by the Division, which are based on model procedures developed by the National Association of Insurance Commissioners ("NAIC"). The examiners relied primarily on records and materials maintained and/or provided by John Alden. The MCE covered the period from January 1, 2009 through December 31, 2009.

The examination included review of the following:

Company Operations and Management
Complaints
Producers
Contract Forms
Rating
New Business Applications and Renewals
Cancellations/Declinations/Non-Renewals/Rescissions
Claims
Utilization Review

The examination report is a report written by exception. References to additional practices, procedures, or files that did not contain any improprieties were omitted. Based on review of these areas, the examiners prepared comment forms that were provided to John Alden. The comment forms set forth any concerns and/or discrepancies identified by the examiners during the course of the examination. The comment forms contained a section that permitted John Alden to submit a written response to the examiners' comments.

For the period under examination, the examiners included statutory citations and regulatory references related to health insurance laws in Colorado. Examination findings may result in administrative action by the Division. The examiners may not have discovered all unacceptable or non-complying practices of John Alden. Failure to identify specific Company practices does not constitute acceptance of such practices. This report should not be construed to either endorse or discredit any insurance company or insurance product.

EXAMINERS' METHODOLOGY

The examiners reviewed John Alden's business practices to determine compliance with Colorado insurance laws as outlined below.

Statute or Regulation	Subject
Section 10-1-128, C.R.S.	Fraudulent insurance acts – immunity for furnishing information relating to suspected insurance fraud – legislative declaration.
Section 10-2-401, C.R.S.	License required.
Section 10-2-702, C.R.S.	Commissions.
Section 10-3-1104, C.R.S.	Unfair methods of competition and unfair or deceptive acts or practices.
Section 10-8-513, C.R.S.	Eligibility for coverage under the program.
Section 10-8-521, C.R.S.	Notice to residents.
Section 10-16-102, C.R.S.	Definitions.
Section 10-16-104, C.R.S.	Mandatory coverage provisions – definitions.
Section 10-16-104.3, C.R.S.	Dependent health coverage for persons under twenty-five years of age – coverage for students who take medical leave of absence.
Section 10-16-104.7, C.R.S.	Substance abuse – court-ordered treatment coverage.
Section 10-16-105, C.R.S.	Small group sickness and accident insurance – guaranteed issue – mandated provisions for basic health benefit plans – rules – benefit design advisory committee – repeal.
Section 10-16-106.3, C.R.S.	Uniform claims – billing codes – electronic claim forms.
Section 10-16-106.5, C.R.S.	Prompt payment of claims – legislative declaration.
Section 10-16-107, C.R.S.	Rate regulation – rules – approval of policy forms – benefit certificates – evidences of coverage – benefits ratio – disclosures on treatment of intractable pain.
Section 10-16-108, C.R.S.	Conversion and continuation privileges.
Section 10-16-113, C.R.S.	Procedure for denial of benefits – internal review –rules.
Section 10-16-113.5, C.R.S.	Independent external review of benefit denials – legislative declaration – definitions.
Section 10-16-113.7, C.R.S.	Reporting the denial of benefits to the division.
Section 10-16-118, C.R.S.	Limitations on preexisting condition limitations.
Section 10-16-201.5, C.R.S.	Renewability of health benefit plans – modification of health benefit plans.
Section 10-16-202, C.R.S.	Required provisions in individual sickness and accident policies.
Section 10-16-214, C.R.S.	Group sickness and accident insurance.
Section 10-16-704, C.R.S.	Network adequacy – rules – legislative declaration – repeal.
Section 10-16-705, C.R.S.	Requirements for carriers and participating providers.
Insurance Regulation 1-1-6	Concerning The Elements Of Certification For Accident and Health Forms
Insurance Regulation 1-1-7	Market Conduct Record Retention
Insurance Regulation 1-1-8	Penalties And Timelines Concerning Division Inquiries And Document Requests
Insurance Regulation 4-2-3	Advertisements of Accident and Sickness Insurance
Insurance Regulation 4-2-5	General Hospital Definition
Insurance Regulation 4-2-6	Concerning the Definition of the Term "Complications of Pregnancy" For Use In Accident And Health Insurance Policies
Insurance Regulation 4-2-8	Concerning Required Health Insurance Benefits For Home Health Services And Hospice Care

Insurance Regulation 4-2-11	Rate Filing and Annual Report Submissions Health Insurance
Insurance Regulation 4-2-13	Mammography Minimum Benefit Level
Insurance Regulation 4-2-16	Women's Access To Obstetricians, Gynecologists And Certified Nurse Midwives Under Managed Care Plans
Insurance Regulation 4-2-17	Prompt Investigation Of Health Plan Claims Involving Utilization Review And Denial Of Benefits
Insurance Regulation 4-2-18	Concerning The Method Of Crediting And Certifying Creditable Coverage For Pre-Existing Conditions
Insurance Regulation 4-2-19	Concerning Individual Health Benefit Plans Issued To Self-employed Business Groups Of One
Insurance Regulation 4-2-20	Concerning the Colorado Health Benefit Plan Description Form
Insurance Regulation 4-2-21	External Review Of Benefit Denials Of Health Coverage Plans
Insurance Regulation 4-2-24	Concerning Clean Claim Requirements For Health Carriers
Insurance Regulation 4-2-27	Procedures For Reasonable Modifications To Individual And Small Group Health Benefit Plans
Insurance Regulation 4-2-30	Concerning The Rules For Complying With Mandated Coverage Of Hearing Aids And Prosthetics
Emergency Regulation 08-E-12	Concerning Small Employer Group Health Benefit Plans And The Basic And Standard Health Benefit Plans
Insurance Regulation 4-6-5	Concerning Small Employer Group Health Benefit Plans And The Basic And Standard Health Benefit Plans
Insurance Regulation 4-6-7	Concerning Premium Rate Setting For Small Group Health Plans
Insurance Regulation 4-6-8	Concerning Small Employer Health Plans
Insurance Regulation 4-6-9	Conversion Coverage

Sampling Methodology

Where sampling was necessary, the examiners reviewed files randomly selected from the larger population of files in accordance with the sampling methodology and sample sizes set forth in the NAIC Market Regulation Handbook ("Handbook"). Otherwise, the examiners reviewed the entire population of files. Per statute, the examiners used the most recent version (2010) of the Handbook available at the commencement of the examination.

In some instances, the issue being reviewed only applied to a small subset of the sample. In these instances, John Alden was afforded the opportunity to agree that the initial sample was representative of the overall population, or to request that an additional/larger sample be selected. In each instance, John Alden indicated that the results of the initial sample were representative of the overall population, and an additional sample was not necessary.

An error tolerance level of seven percent (7%) for claims, and ten percent (10%) for other samples, was established, per the Handbook, to determine reportable exceptions.

Prior Examinations

This is an initial examination of John Alden performed by the Division.

Company Operations and Management

The examiners reviewed Company management and administrative controls, the Certificate of Authority, record retention, administrative, underwriting and claims guidelines/procedures, and timely cooperation with the examination process.

Producers

The examiners reviewed the licensing status of the submitting producers for all small group business written during the period of the examination for compliance with the appropriate Colorado statutes and regulations.

Contract Forms

The examiners reviewed the following policy forms for compliance with Colorado statutes and regulations:

- Small Group J4000 (Group Trust)
- CO Basic
- CO Basic HD-CC
- CO JA Standard-CC
- 376 RightStart PPO with Maternity
- 376 RightStart HSA Traditional
- 376 SaveRight PPO
- 376 SaveRight Traditional
- JIM.POL.CO CoreMed with Maternity
- JIM.POL.CO Max Plan
- JIM.POL.CO CoreMed 1.1.09-6.30.09
- JIM.POL.CO. CoreMed 7.1.09-12.31.09
- JIM.POL.CO One Deductible Traditional
- JIM.POL.CO One Deductible PPO
- Short Term 146
- Maternity Rider
- Individual Insurance Application — JI-2100-CO
- Individual Insurance Application — JI-2200
- Individual Insurance Application — JI-23300-CO
- Individual Insurance Application — JI2700-CO.12.08 Rev. 12/2008
- Individual Insurance Application — JI2800-CO.6.09 Rev. 06/2009
- Short-Term Medical Application — JT-1147-CO Rev. 06/2009
- Employee Enrollment Form — HC-1871-CO
- CO Uniform Application — CO SG 01 Rev.7/25/06

New Business Applications and Renewals

The examiners reviewed the following for compliance with statutory requirements and contractual obligations with samples derived according to guidelines from the Handbook:

- One hundred thirteen (113) individual new business application files sampled from a population of 548;
- One hundred thirteen (113) new short-term medical new business applications sampled from a population of 543;
- The entire population of thirteen (13) small group new business application files;
- Eighty-four (84) individual renewal files sampled from a population of 254; and
- Seventy-nine (79) small group renewal files sampled from a population of 131.

Rating

The examiners reviewed the premium rates charged in the samples of new business individual files and for both new and renewal small group sample files. These rates were reviewed for compliance with the rate filings submitted to the Division as the rates being used during the examination period as well as for compliance with the appropriate statutes and regulations.

Cancellations/Declinations/Non-Renewals/Rescissions

The examiners reviewed the following samples, derived according to guidelines from the Handbook, for compliance with statutory requirements and contractual obligations:

- Eighty-four (84) individual cancellation/non-renewal files from a population of 303;
- One hundred thirteen (113) short-term medical cancellation/non-renewal files from a population of 579;
- Seventy-nine (79) small group cancellation/non-renewal files from a population of 96;
- Eighty-four (84) individual declined files from a population of 242;
- The entire population of twenty-eight (28) short-term medical declined files; and
- The entire population of nine (9) individual rescission files.

Claims

The examiners reviewed the following claims samples, derived according to guidelines from the Handbook, for compliance with statutory requirements and contractual obligations:

The following two samples were reviewed for overall claim handling and accuracy of processing.

- One hundred nine (109) paid claims from a population of 43,727; and
- One hundred nine (109) denied claims from a population of 13,342.

The following three samples were reviewed to determine John Alden's compliance with Colorado's prompt payment of claims law.

- One hundred five (105) electronic claims from a population of 1,453 electronic (over 30 days) claims;

- One hundred five (105) non-electronic claims from a population of 794 non-electronic (over 45 days) claims; and
- Eighty-three (83) electronic and non-electronic claims from a population of 443 (over 90 days) electronic and non-electronic claims received during the examination period.

Utilization Review

The examiners reviewed John Alden's utilization review (UR) management program including policies and procedures. The examiners also reviewed the following UR samples, derived according to guidelines from the Handbook, for compliance with statutory requirements:

- Seventy-nine (79) UR approval files from a population of 92;
- The entire population of twelve (12) UR declination files; and
- The entire population of four (4) First Level UR appeal files.

John Alden reported no Second Level Appeals or External Reviews for the period under examination.

EXAMINATION REPORT SUMMARY

The examination resulted in a total of twenty-nine (29) findings in which John Alden was not in compliance with Colorado statutes and regulations. The following is a summary of the examiners' findings.

Company Operations and Management: In the area of Company Operations and Management, no compliance issues were identified that met the reporting threshold to be included in this report

Complaints: In the area of Complaints, no compliance issues were identified that met the reporting threshold to be included in this report.

Contract Forms: The examiners identified twenty-five (25) areas of concern in their review of John Alden's contract forms (including evidence of coverage forms, employer/employee applications, group service contracts, and riders).

Issue E1: Failure of the Company's forms, in some instances, to include the required provisions for coverage of cervical cancer vaccines.

Issue E2: Failure of the Company's forms, in some instances, to include the required provisions of coverage for hearing aids for minor children.

Issue E3: Failure of the Company's forms, in some instances, to include the required provisions for coverage of organ transplants.

Issue E4: Failure of the Company's forms, in some instances, to include correct provisions for outpatient physical, occupational, and speech therapy and therapies for congenital defects and birth abnormalities in children up to six years of age.

Issue E5: Failure, in some instances, to include accurate information in preferred provider organization (PPO) plan forms regarding preauthorization responsibility.

Issue E6: Failure, in some instances, to reflect correct or complete provisions of coverage for prosthetic devices in accordance with requirements of Colorado insurance law.

Issue E7: Failure of the Company's forms, in some instances, to include correct coverage to be provided for home health services as required by Colorado insurance law.

Issue E8: Failure of the Company's forms, in some instance, to provide accurate information regarding payment of claims after preauthorization or approval for services.

Issue E9: Failure of the Company's forms, in some instance, to provide notification of the availability of conversion to a Basic or Standard Health Benefit Plan to an employee, dependent or member upon termination of group coverage.

Issue E10: Failure of the Company's Basic and Standard Health Benefit Plan forms to reflect the correct lifetime or benefit maximums in accordance with Colorado insurance law.

Issue E11: Failure of the Company's forms, in some instances, to include provisions for coverage of early intervention services.

Issue E12: Failure of the Company's forms, in some instances, to reflect a complying definition of a preexisting condition under Colorado insurance law.

Issue E13: Failure of the Company's forms, in some instances, to reflect correct reasons for termination of coverage.

Issue E14: Failure of the Company's forms, in some instances, to reflect correct information regarding requests for Independent External Reviews.

Issue E15: Failure of the Company's forms, in some instances, to offer dependent coverage up to twenty-five years of age.

Issue E16: Failure of the Company's forms, in some instances, to reflect coverage provisions for colorectal cancer screenings.

Issue E17: Failure of the Company's forms, in some instances, to provide accurate information related to out-of-pocket annual maximums.

Issue E18: Failure of the Company's forms, in some instances, to provide accurate information related to annual deductibles.

Issue E19: Failure of the Company's Basic and Standard Health Benefit Plan forms to outline the benefits provided in the required form with the required content.

Issue E20: Failure of the Company's forms, in some instances, to reflect complete or accurate information related to prescription coverage.

Issue E21: Failure of the Company's forms, in some instances, to reflect accurate information related to preventive care.

Issue E22: Failure of the Company's forms, in some instances, to reflect accurate information related to ambulance coinsurance.

Issue E23: Failure of the Company's forms, in some instances, to reflect accurate information related to biologically based mental illness benefits.

Issue E24: Failure of the Company's forms, in some instances, to reflect accurate information related to hospice care.

Issue E25: Failure of the Company's forms, in some instances, to include provisions for newborn children coverage as required by Colorado insurance law.

New Business Applications and Renewals: In the area of New Business Application and Renewals, no compliance issues were identified that met the reporting threshold to be included in this report.

Cancellations/Non-Renewals/Declinations/Rescissions: The examiners identified two (2) areas of concern identified during the review of John Alden's cancellations, non-renewals, declination, and rescission files.

Issue H1: Failure, in some instances, to provide written notice of the availability of small group coverage to business groups of one upon denial of coverage under an individual plan.

Issue H2: Failure, in some instances, to offer to each member of terminating small groups a choice of the Basic or Standard Health Benefit Plan.

Claims: The examiners identified two (2) areas of concern in their review of the claims handling practices of John Alden.

Issue J1: Failure, in some instances, to pay, deny or settle claims within the time periods required by Colorado insurance law.

Issue J2: Failure, in some instances, to pay a penalty on claims not paid, denied, or settled within ninety (90) days.

Utilization Review: In the area of Utilization Review, no compliance issues were identified that met the reporting threshold to be included in this report.

FACTUAL FINDINGS

CONTRACT FORMS

Issue E1: Failure of the Company's forms, in some instances, to include the required provisions for coverage of cervical cancer vaccines.

Section 10-16-104, C.R.S., Mandatory coverage provisions-definitions, states in part:

. . .

(17) Cervical cancer vaccines.

(a) All individual and all group sickness and accident insurance policies, except supplemental policies covering a specified disease or other limited benefit, that are delivered or issued for delivery within the state by an entity subject to the provisions of part 2 of this article and all individual and group health care service or indemnity contracts issued by an entity subject to the provisions of part 3 or 4 of this article, as well as any other group health care coverage offered to residents of this state, *shall provide coverage for the full cost of cervical cancer vaccination for all females for whom a vaccination is recommended* by the advisory committee on immunization practices of the United States department of health and human services.

(b) *The requirements of this subsection (17) shall apply to all individual sickness and accident insurance policies and health care service or indemnity contracts issued on or after January 1, 2008, and to all group accident and sickness policies and group health care service or indemnity contracts issued, renewed, or reinstated on or after January 1, 2008.* [Emphases added.]

John Alden was not in compliance with Colorado insurance law in that, in some instances, its health benefit plan forms did not provide for the mandated coverage of cervical cancer vaccines. The following forms failed to contain the required provision for this coverage.

Form Name	Date:
CO Basic	3/1995
CO JA Basic HD-CC	3/2006
CO JA Standard-CC	3/2006
Small Group J4000	No date
JIM.POL.CO Max Plan	No date
JIM.POL.CO CoreMed	01/1/09-09/30/09
JIM.POL.CO CoreMed	07/1/09-12/31/09
JIM.POL.CO One Deductible Traditional	No date
JIM.POL.CO One Deductible PPO	No date
JIM.POL.CO CoreMed w/Maternity	No date
376 Right Start PPO	No date
376 Right Start w/Maternity	No date
376 Right Start HSA Traditional	01/1/09-12/31/09
376 SaveRight PPO	01/01/09-12/31/09
376 SaveRight Traditional	01/1/09-12/31/09

Recommendation No. 1:

John Alden shall be provided a reasonable period, not exceeding thirty (30) days from the date of this report, to make written submission or rebuttal as to why it should not be considered in violation of § 10-16-104, C.R.S. In the event John Alden is unable to provide such documentation, the Company may include, with its submission or rebuttal, its plan to comply, or documentation showing it is now in compliance.

Otherwise, John Alden shall be required, within sixty (60) days from the date this report is adopted, to provide written evidence to the Division that it has revised all applicable forms to reflect the mandatory coverage for cervical cancer vaccines as required by Colorado insurance law. Within these sixty (60) days, John Alden shall also provide the Division with specimen copies of all revised policy forms containing compliant provisions for coverage of cervical cancer vaccines and the proposed date that the forms will be put in use.

Issue E2: Failure of the Company's forms, in some instances, to include the required provisions of coverage for hearing aids for minor children.

Section 10-16-104, C.R.S., Mandatory coverage provisions – definitions, states in part:

. . .

(19) Hearing aids for children – legislative declaration.

(a) The general assembly hereby finds and determines that the language development of children with partial or total hearing loss may be impaired due to the hearing loss. Children learn the concept of spoken language through auditory stimuli, and the language skills of children who have hearing loss improve when they are provided with hearing aids and access to visual language upon the discovery of hearing loss. The general assembly therefore declares that providing hearing aids to children with hearing loss will reduce the costs borne by the state, including special education, alternative treatments that would otherwise be necessary if a hearing aid were not provided, and other costs associated with such hearing loss.

(b) *Any health benefit plan that provides hospital, surgical, or medical expense insurance, except supplemental policies covering a specified disease or other limited benefit, shall provide coverage for hearing aids for minor children who have a hearing loss that has been verified by a physician licensed pursuant to article 36 of title 12, C.R.S., and by an audiologist licensed pursuant to section 12-5.5-102, C.R.S.* The hearing aids shall be medically appropriate to meet the needs of the child according to accepted professional standards. Coverage shall include the purchase of the following: [Emphasis added.]

(I) Initial hearing aids and replacement hearing aids not more frequently than every five years;

(II) A new hearing aid when alterations to the existing hearing aid cannot adequately meet the needs of the child;

(III) Services and supplies including, but not limited to, the initial assessment, fitting, adjustments, and auditory training that is provided according to accepted professional standards.

(c) The benefits accorded pursuant to this subsection (19) shall be subject to the same annual deductible or copayment established for all other covered benefits within the insured's policy and utilization review as provided in sections 10-16-112, 10-16-113, and 10-16-113.5. The benefits shall also be subject to part 7 of this article.

(d) Health benefit plans issued by an entity subject to this part 1 may provide that the benefits required pursuant to this section shall be covered benefits only if the services are deemed medically necessary.

Colorado Insurance Regulation 4-2-30, Concerning the Rules for Complying with Mandated Coverage of Hearing Aids and Prosthetics, promulgated under the authority of § 10-1-109, C.R.S., states in part:

. . .

Section 3 Applicability

This regulation applies to all individual and group health benefit plans issued or renewed on or after January 1, 2009 by entities subject to Part 2, Part 3 and Part 4 of Article 16 of Title 10 of the Colorado Revised Statutes.

Section 4 Definitions

. . .

C. "Hearing aid" shall have the same meaning as set forth in § 10-16-102(24.7), C.R.S.

. . .

E. "Minor child" shall have the same meaning as set forth in § 10-16-102(27.3), C.R.S.

Section 5 Rules

A. Hearing aids.

1. For the purposes of § 10-16-104(19), C.R.S., hearing aids do not meet the traditional definition of durable medical equipment; therefore, any benefits paid for a minor child's hearing aid(s) in accordance with the coverage mandated by Colorado law shall not be used to exhaust a health benefit plan's annual or lifetime durable medical equipment maximum, if any.

2. The mandated coverage of hearing aids for a minor child shall be provided subject to the same annual deductible and/or copayment/coinsurance levels established for other covered benefits. Benefits shall be determined by where the hearing aid is accessed (i.e. an office visit copay will apply if the hearing aid is provided as part of an office visit). These benefits are subject to the policy's general annual and/or lifetime maximum benefit amounts. Hearing aids are subject to utilization review as provided in §§ 10-16-112, 10-16-113, and 10-16-113.5, C.R.S.

3. The coverage includes the initial assessment, fitting, adjustments, and the required auditory training. Initial hearing aids and replacement hearing aids are not covered more frequently than every five (5) years; however, a new hearing aid is covered when alterations to the existing hearing aid cannot adequately meet the needs of the child. This requirement shall apply to each hearing aid if the minor child has two hearing aids.

John Alden was not in compliance with Colorado insurance law in that the Company's group and individual health benefit plan forms, in some instances, did not provide for the mandated coverage of hearing aids for dependent children. The following forms were not in compliance with Colorado insurance law:

Form/Plan:	Date:
CO Basic	3/1995
CO JA Basic HD-CC	3/2006
CO JA Standard-CC	3/2006
Small Group J4000	No date
JIM.POL.CO Max Plan	No date
JIM.POL.CO CoreMed	01/1/09-09/30/09
JIM.POL.CO CoreMed	07/1/09-12/31/09
JIM.POL.CO One Deductible Traditional	No date
JIM.POL.CO One Deductible PPO	No date
JIM.POL.CO CoreMed w/Maternity	No date
376 Right Start PPO	No date
376 Right Start w/Maternity	No date
376 Right Start HSA Traditional	01/1/09-12/31/09
376 SaveRight PPO	01/01/09-12/31/09
376 SaveRight Traditional	01/1/09-12/31/09

Recommendation No. 2:

John Alden shall be provided a reasonable period, not exceeding thirty (30) days from the date of this report, to make written submission or rebuttal as to why it should not be considered in violation of § 10-16-104, C.R.S., and Colorado Insurance Regulation 4-2-30. In the event John Alden is unable to provide such documentation, the Company may include, with its submission or rebuttal, its plan to comply, or documentation showing it is now in compliance.

Otherwise, John Alden shall be required, within sixty (60) days from the date this report is adopted, to provide written evidence to the Division that it has revised all applicable forms to provide coverage for hearing aids for minor children as required by Colorado insurance law. Within these sixty (60) days, John Alden shall also provide the Division with specimen copies of all revised policy forms containing compliant provisions for coverage of hearing aids for minor children and provide the proposed date that the forms will be put in use.

Issue E3: Failure of the Company's forms, in some instances, to include the required provisions for coverage of organ transplants.

Section 10-16-104, C.R.S., Small group sickness and accident insurance – guaranteed issue – mandated provisions for basic health benefit plans – rules – benefit design advisory committee – repeal, states in part:

. . .

(7.2) The commissioner shall promulgate rules to implement a basic health benefit plan and a standard health benefit plan to be offered by each small employer carrier as a condition of transacting business in this state. The commissioner shall survey small group carriers annually to determine the range of health benefits available. The commissioner shall implement a basic plan that approximates the lowest level of coverage offered in small group health benefit plans. A basic health benefit plan may be based upon the latest medical evidence. The commissioner shall implement a standard plan that approximates the average level of coverage offered in small group health benefit plans. In determining levels of coverage, the commissioner shall consider factors such as coinsurance, copayments, deductibles, out-of-pocket maximums, and covered benefits. The commissioner shall amend the rules as necessary to implement the basic and standard health benefit plans. The rules shall be in conformity with article 4 of title 24, C.R.S., and shall incorporate the following standard health benefit plan design describe in paragraph (a) of this subsection (7.2) and the various options for the basic health benefit plan design described in paragraph (b) of this subsection (7.2).

Emergency Insurance Regulation 08-E-12 and Amended Regulation 4-6-5, Concerning Small Employer Group Health Benefit Plans and The Basic and Standard Health Benefit Plans, promulgated under the authority of §§ 10-1-109, 10-16-105(7.2), 10-16-108.5(8), and 10-16-109, C.R.S. state in part:*

*Emergency Regulation 08-E-12 (effective January 1, 2009) was replaced in its entirety by Amended Regulation 4-6-5, which was effective February 1, 2009. Other than the effective dates, the required benefits are identical for both regulations.

. . .

Section 3 Applicability

This regulation shall apply to all small employer carriers as defined in §10-16-102(41), C.R.S., and to all carriers required to provide conversion products pursuant to §10-16-108, C.R.S.

Section 4 Rules*

A. Plans

1. Basic Plan. The form and content of the basic health benefit plan may be one or more of the three plan design options as appended to this regulation and shall constitute the basic health benefit plan design

pursuant to §10-16-105(7.2), C.R.S. At least one of these three plan design options, two of which are high deductible, HSA-qualified plan options, shall be required for use in Colorado's small employer group market pursuant to §10-16-105(7.3), C.R.S., and as conversion coverage pursuant to §10-16-108, C.R.S. However, if the carrier chooses to offer more than one basic health benefit plan design, it shall offer all of its basic plan options to every small employer that expresses an interest in the basic health benefit plan or to those individuals purchasing a basic conversion plan.

2. Standard Plan. The form and content of the standard health benefit plan, as appended to this regulation, shall constitute the standard health benefit plan required for use in Colorado's small employer group market pursuant to §10-16-105(7.3), C.R.S., and for use as conversion coverage pursuant to §10-16-108, C.R.S.

BASIC AND STANDARD HEALTH BENEFIT PLAN
POLICY REQUIREMENTS FORTHE STATE OF COLORADO

Colorado Division of Insurance
Effective January 1, 2009

1. The basic health benefit plan as defined by the Commissioner pursuant to §10-16-105(7.2)(b), C.R.S., for an indemnity, preferred provider organization (PPO), and health maintenance organization (HMO) plan shall include the specific benefits and coverages outlined in one of the attached tables labeled "Basic Limited Mandate Health Benefit Plan", "Basic HSA Health Benefit Plan", or "Basic HSA Limited Mandate Health Benefit Plan".

2. The standard health benefit plan for an indemnity, PPO, and HMO plan shall include the specific benefits and coverages outlined in the attached table labeled "Standard Health Benefit Plan".

JANUARY 1, 2009 COLORADO BASIC LIMITED MANDATE HEALTH BENEFIT PLANS:

INDEMNITY, PPO

PART B: SUMMARY OF BENEFITS

(Please note: all coinsurance percentages listed are what the carrier will pay for service.)

	BASIC INDEMNITY PLAN	**BASIC PPO PLAN**	
BASIC LIMITED MANDATE HEALTH BENEFIT PLAN		**IN-NETWORK**	**OUT-OF-NETWORK** [2]
24. ORGAN TRANSPLANTS [18]	Covered transplants include: liver, heart, heart/lung, lung, cornea, kidney, kidney/pancreas, other single and multi-organ transplants, and bone marrow for Hodgkin's, aplastic anemia, leukemia, immunodeficiency disease, neuroblastoma, lymphoma, high risk stage II and III breast cancer, and Wiskott-Aldrich syndrome only. Peripheral stem cell support is a covered benefit for the same conditions as listed above for bone marrow transplants.		
	50% coinsurance	70% coinsurance	50% coinsurance

[18] Transplants will be covered only if they are medically necessary and meet clinical standards for the procedure.

JANUARY 1, 2009 COLORADO BASIC HSA LIMITED MANDATE HEALTH BENEFIT PLANS:

INDEMNITY, PPO

PART B: SUMMARY OF BENEFITS

(Please note: all coinsurance percentages listed are what the carrier will pay for service.)

	BASIC INDEMNITY PLAN	**BASIC PPO PLAN**	
Basic HSA Limited Mandate Health Benefit Plan		**IN-NETWORK**	**OUT-OF-NETWORK[1a]**
24. ORGAN TRANSPLANTS [17]	Covered transplants include: liver, heart, heart/lung, lung, cornea, kidney, kidney/pancreas, other single and multi-organ transplants, and bone marrow for Hodgkin's, aplastic anemia, leukemia, immunodeficiency disease, neuroblastoma, lymphoma, high risk stage II and III breast cancer, and Wiskott-Aldrich syndrome only. Peripheral stem cell support is a covered benefit for the same conditions as listed above for bone marrow transplants.		
	50% coinsurance	70% coinsurance	50% coinsurance

[17] Transplants will be covered only if they are medically necessary and meet clinical standards for the procedure.

JANUARY 1, 2009 COLORADO STANDARD HEALTH BENEFIT PLANS: INDEMNITY, PPO

PART B: SUMMARY OF BENEFITS

(Please note: all coinsurance percentages listed are what the carrier will pay for service.)

		STANDARD PPO PLAN	
	STANDARD INDEMNITY PLAN	**IN-NETWORK**	**OUT-OF-NETWORK** [2]
24. ORGAN TRANSPLANTS [22]	Covered transplants include: liver, heart, heart/lung, lung, cornea, kidney, kidney/pancreas, other single and multi-organ transplants, and bone marrow for Hodgkin's, aplastic anemia, leukemia, immunodeficiency disease, neuroblastoma, lymphoma, high risk stage II and III breast cancer, and Wiskott-Aldrich syndrome only. Peripheral stem cell support is a covered benefit for the same conditions as listed above for bone marrow transplants.		
	80% coinsurance	80% coinsurance	50% coinsurance

[22] Transplants will be covered only if they are medically necessary and meet clinical standards for the procedure.

John Alden was not in compliance with Colorado insurance law in that its Individual Conversion Policy [Basic Limited Mandate Health Benefit Plan]; [Indemnity] [Preferred Provider] Basic HSA Limited Mandate Health Benefit Plan for Colorado, and [Indemnity] [Preferred Provider] Standard Health Benefit Plan for Colorado forms failed to provide coverage for "other single and multi-organ transplants" required by Colorado Insurance Regulation 4-6-5.

In addition, John Alden's restrictions regarding transplants are also noncompliant in that they:

- prohibited any non-human (including animal or mechanical) organ transplant;
- required that "candidates for liver transplants must have abstained from alcohol for one year immediately prior to transplantation";
- restricted multiple organ, tissue and cellular transplants during one operative session to heart/lung, double lung or simultaneous kidney/pancreas transplants; and
- excluded coverage for transplants approved for a specific condition, but applied to another condition rather than on the basis of medical necessity and clinical standards for the procedure.

John Alden's Basic form, Individual Health Benefit Conversion Policy [Basic Limited Mandate Health Benefit Plan], stated in part:

> **Covered Medical Charges**
>
> Covered Medical Charges must be Medically Necessary and incurred by You, or Your Insured Dependent, while insured. A charge is deemed incurred as of the date of the service, treatment or purchase giving rise to the charge. Subject to the

"Charges Not Covered" and "Limitations" sections that follow, Covered Medical Charges include charges:

. . .

23. For the following human-to-human organ transplants that meet the clinical requirements of the facility where the transplant is performed:
    a. heart;
    b. liver;
    c. kidney;
    d. cornea;
    e. bone marrow for aplastic anemia, leukemia, immunodeficiency disease, and Wiskott-Alrich (sic) syndrome.

Charges Not Covered

. . .

24. For organ and tissue transplants, except as specifically stated in this Policy, or for animal-to-human transplants, or for implantation within the human body of artificial or mechanical devices designed to replace human organ(s). [Emphasis added.]

John Alden's Basic High Deductible form, [Indemnity] [Preferred Provider] Basic HSA Limited Mandate Health Benefit Plan for Colorado, stated in part:

COVERED MEDICAL CHARGES
and
CHARGES NOT COVERED

We will cover charges for any organ, tissue or cellular transplants reviewed and approved by John Alden Life Insurance Utilization Review or Case Management department prior to transplantation evaluation, testing or donor search:

Covered charges include the following solid organ transplants and marrow reconstitution or support:

Solid Organ Transplants
- Heart
- Lung
- Combined heart/lung
- Combined Kidney/pancreas
- Liver (Candidates for liver transplantation must have abstained from alcohol for one year immediately prior to transplantation.)
- Kidney
- Cornea
- Bone marrow for Hodgkin's, aplastic anemia, leukemia, immunodeficiency disease, neuroblastoma, lymphoma, high risk stage II and III breast cancer, and Wiskott-Aldrich syndrome only.

- Peripheral stem cell support for the same conditions as listed above for bone marrow transplants.

We will not cover charges:

[1. For multiple organ, tissue and cellular transplants during one operative session, except for a heart/lung, double lung or simultaneous kidney/pancreas transplant;]
[2. For any non-human (including animal or mechanical) organ transplant;]
[3. For transplants approved for a specific medical condition, but applied to another condition;]
[4. For the purchase of an organ or tissue; or]
[5. For any charge in excess of the maximums described above.] [Emphases added.]

John Alden's Indemnity/Preferred Provider Standard Health Benefit Plan for Colorado stated in part:

COVERED MEDICAL CHARGES
and
CHARGES NOT COVERED

. . .

VII. TRANSPLANT BENEFITS

We will cover charges:
For any organ, tissue or cellular transplants reviewed and approved by John Alden Life Insurance Utilization Review or Case Management department prior to transplantation evaluation, testing or donor search:

Covered charges include the following solid organ transplants and marrow reconstitution or support:

- Heart
- Lung
- Combined heart/lung
- Combined Kidney/pancreas
- Liver (Candidates for liver transplantation must have abstained from alcohol for one year immediately prior to transplantation.)
- Kidney
- Cornea
- Bone marrow for Hodgkin's, aplastic anemia, leukemia, immunodeficiency disease, neuroblastoma, lymphoma, high risk stage II and III breast cancer, and Wiskott-Aldrich syndrome only.
- Peripheral stem cell support for the same conditions as listed above for bone marrow transplants.

We will not cover charges:

[1. For multiple organ, tissue and cellular transplants during one operative session, except for a heart/lung, double lung or simultaneous kidney/pancreas transplant;]
[2. For any non-human (including animal or mechanical) organ transplant;]
[3. For transplants approved for a specific medical condition, but applied to another condition;]

[4. For the purchase of an organ or tissue; or]
[5. For any charge in excess of the maximums described above.] [Emphases added.]

The following forms were not in compliance with Colorado insurance law with regard to mandated coverage for organ transplants:

Form:	Date
CO Basic	3/1995
CO JA Basic HD-CC	3/2006
CO JA Standard-CC	3/2006

Recommendation No. 3:

John Alden shall be provided a reasonable period, not exceeding thirty (30) days from the date of this report, to make written submission or rebuttal as to why it should not be considered in violation of § 10-16-104, C.R.S., and Emergency Insurance Regulation 08-E-12 and Amended Insurance Regulation 4-6-5. In the event John Alden is unable to provide such documentation, the Company may include, with its submission or rebuttal, its plan to comply, or documentation showing it is now in compliance.

Otherwise, John Alden shall be required, within sixty (60) days from the date this report is adopted, to provide written evidence to the Division that it has revised all applicable forms to reflect correct benefits for organ transplants as required by Colorado insurance law. Within these sixty (60) days, John Alden shall also provide the Division with specimen copies of all revised policy forms containing compliant provisions for coverage of organ transplants and provide the proposed date that the forms will be put in use.

Issue E4: Failure of the Company's forms, in some instances, to include correct provisions for outpatient physical, occupational, and speech therapy and therapies for congenital defects and birth abnormalities in children up to six years of age.

Section 10-16-104, C.R.S., Mandatory coverage provisions – definitions, states in part:

. . .

(1.3) Early intervention services. (a) As used in this subsection (1.3), unless the context otherwise requires:

(b)(IV) The limit on the amount of coverage for early intervention services specified in subparagraph (II) of this paragraph (b) shall not apply to:

(B) Services provided to a child who is not participating in part C and services that are not provided pursuant to an IFSP. However, such services shall be covered at the level specified in paragraph (b) of subsection (1.7) of this section.

(1.7) Therapies for congenital defects and birth abnormalities

(a) After the first thirty-one days of life, policy limitations and exclusions that are generally applicable under the policy may apply; except that *all individual and group health benefit plans shall provide medically necessary physical, occupational, and speech therapy for the care and treatment of congenital defects and birth abnormalities for a covered child from the child's third birthday to the child's sixth birthday.*

(b) The level of benefits required in paragraph (a) of this subsection (1.7) shall be the greater of the number of such visits provided under the policy or plan or twenty therapy visits per year each for physical therapy, occupational therapy, and speech therapy. Said therapy visits shall be distributed as medically appropriate throughout the yearly term of the policy or yearly term of the enrollee coverage contract, without regard to whether the condition is acute or chronic and *without regard to whether the purpose of the therapy is to maintain or to improve functional capacity*. [Emphases added.]

Colorado Emergency Insurance Regulation 08-E-12 and Amended Regulation 4-6-5, Concerning Small Employer Group Basic and Standard Health Benefit Plans and The Basic and Standard Health Benefit Plans Policy Requirements for the State of Colorado, promulgated under the authority of §§ 10-1-109, 10-16-105(7.2), 10-16-108.5(8), and 10-16-109, C.R.S. state in part:*

*Emergency Regulation 08-E-12 (effective January 1, 2009) was replaced in its entirety by Amended Regulation 4-6-5, which was effective February 1, 2009. Other than the effective dates, the required benefits are identical for both regulations.

. . .

Section 3 Applicability

This regulation shall apply to all small employer carriers as defined in §10-16-102(41), C.R.S., and to all carriers required to provide conversion products pursuant to §10-16-108, C.R.S.

Section 4 Rules

A. Plans

1. Basic Plan. The form and content of the basic health benefit plan may be one or more of the three plan design options as appended to this regulation and shall constitute the basic health benefit plan design pursuant to §10-16-105(7.2), C.R.S. At least one of these three plan design options, two of which are high deductible, HSA-qualified plan options, shall be required for use in Colorado's small employer group market pursuant to §10-16-105(7.3), C.R.S., and as conversion coverage pursuant to §10-16-108, C.R.S. However, if the carrier chooses to offer more than one basic health benefit plan design, it shall offer all of its basic plan options to every small employer that expresses an interest in the basic health benefit plan or to those individuals purchasing a basic conversion plan.

2. Standard Plan. The form and content of the standard health benefit plan, as appended to this regulation, shall constitute the standard health benefit plan required for use in Colorado's small employer group market pursuant to §10-16-105(7.3), C.R.S., and for use as conversion coverage pursuant to §10-16-108, C.R.S.

BASIC AND STANDARD HEALTH BENEFIT PLAN
POLICY REQUIREMENTS FORTHE STATE OF COLORADO

Colorado Division of Insurance
Effective January 1, 2009

JANUARY 1, 2009 COLORADO BASIC LIMITED MANDATE HEALTH BENEFIT PLANS:

INDEMNITY, PPO

PART B: SUMMARY OF BENEFITS
(Please note: all coinsurance percentages listed are what the carrier will pay for the service.)

	BASIC INDEMNITY PLAN	**BASIC PPO PLAN**	
BASIC LIMITED MANDATE HEALTH BENEFIT PLAN		**IN-NETWORK**	**OUT-OF-NETWORK [2]**
21.OUTPATIENT PHYSICAL, OCCUPATIONAL & SPEECH THERAPY [16]	50% coinsurance **(Limited to 25** ***visits per therapy per year)***	70% coinsurance ***(Limited to 25 visits per therapy per year combined in and out-network)***	50% coinsurance ***Limited to 25 visits per therapy per year combined in and out-network*****)**

[16] Coverage for medically necessary therapeutic treatment only; benefits will not be paid for maintenance therapy after maximum medical improvement achieved, except as required by law for children under 6 years of age. The services covered and the benefits provided for children under 6 years of age must be in accordance with the requirements of §10-16-104, C.R.S., subsections (1.3) and (1.7).

JANUARY 1, 2009 COLORADO BASIC HSA LIMITED MANDATE HEALTH BENEFIT PLANS:

INDEMNITY, PPO

PART B: SUMMARY OF BENEFITS

(Please note: all coinsurance percentages listed are what the *carrier* will pay for service.) [Emphasis added.]

	BASIC INDEMNITY PLAN	**BASIC PPO PLAN**	
Basic HSA Limited Mandate Health Benefit Plan		**IN-NETWORK**	**OUT-OF-NETWORK[1a]**
21. OUTPATIENT PHYSICAL, OCCUPATIONAL & SPEECH THERAPY [14]	50% coinsurance ***(Limited to 25 visits per therapy per year)***	70% coinsurance	50% coinsurance
		(Limited to 25 visits per therapy per year combined in- and out-network)	

[14] Coverage for medically necessary therapeutic treatment only; benefits will not be paid

for maintenance therapy after maximum medical improvement achieved, except as required by law for children under 6 years of age. The services covered and the benefits provided for children under 6 years of age must be in accordance with the requirements of §10-16-104, C.R.S., subsections (1.3) and (1.7).

JANUARY 1, 2009 COLORADO STANDARD HEALTH BENEFIT PLANS: INDEMNITY, AND PPO

PART B: SUMMARY OF BENEFITS

(Please note: all coinsurance percentages listed are what the carrier will pay for service.)

		STANDARD PPO PLAN	
	STANDARD INDEMNITY PLAN	**IN-NETWORK**	**OUT-OF-NETWORK** [2]
21. OUTPATIENT PHYSICAL, OCCUPATIONAL & SPEECH THERAPY [20]	80% coinsurance ***(Limited to 25 visits per therapy per year)***	80% coinsurance	50% coinsurance
		(Limited to 25 visits per therapy per year combined in and out-network)	

[20] Coverage for medically necessary therapeutic treatment only; benefits will not be paid for maintenance therapy after maximum medical improvement achieved, except as required by law for children under 6 years of age. The services covered and the benefits provided for children under 6 years of age must be in accordance with the requirements of §10-16-104, C.R.S., subsections (1.3) and (1.7).

John Alden was not in compliance with Colorado insurance law in that its Basic HSA Limited Mandate Health Benefit Plan and Standard Health Benefit Plan forms failed to provide coverage for outpatient physical, occupational, and speech therapy at the level required by Emergency Insurance Regulation 08-E-12 and Amended Insurance Regulation 4-6-5. John Alden's Basic and Standard Plans covered a combined total of twenty (20) outpatient physical, occupational, and speech therapy sessions per year, instead of the required twenty-five (25) sessions of each therapy per year.

Additionally, John Alden's Individual Conversion Policy [Basic Limited Mandate Health Benefit Plan] form was not in compliance with Colorado insurance law in that the coverage for mandated therapies indicated the therapies were a covered benefit only if they were provided to attain a previous level of function. This provision failed to provide the twenty-five (25) sessions of each therapy per year for outpatient physical, occupational, and speech therapy as required by Emergency Insurance Regulation 08-E-12 and Amended Insurance Regulation 4-6-5.

John Alden's individual health plan forms were not in compliance with Colorado insurance law in that the coverage for mandated therapies indicated the therapies were a covered benefit only if they were provided to attain a previous level of function. As stated in § 10-16-104, C.R.S., subsections (1.3) & (1.7), the coverage required for children up to age six (6) is twenty (20) sessions of each therapy per year, without regard to whether the purpose of the therapy is to maintain or to improve functional capacity.

John Alden's Standard Health Benefit plan stated, in part:

> . . .
>
> **III. OUTPATIENT THEREAPIES**
>
> **We will cover charges:**
>
> 1. *For physical, occupational and speech therapy rendered by a licensed physician or a licensed therapist. Benefits are subject to a rate of payment shown on your benefit summary, and are limited to [25] total visits per year [combined for In- and Out-of-Network services]*. [Emphasis added.]

John Alden's Basic HSA Limited Mandate Health Benefit plan, stated in part:

> . . .
>
> **III. OUTPATIENT THEREAPIES**
>
> **We will cover charges:**
>
> 1. *For physical, occupational and speech therapy rendered by a licensed physician or a licensed therapist. Benefits are subject to a rate of payment shown on your benefit summary, and are limited to [25] total visits per year [combined for In- and Out-of-Network services]*. [Emphasis added.]

John Alden's Individual Health Benefit Conversion Policy [Basic Limited Mandate Health Benefit plan], stated in part:

> **Covered Medical Charges**
>
> Covered Medical Charges must be Medically Necessary and incurred by You, or Your insured Dependent, while insured. A charge is deemed incurred as of the date of the service, treatment or purpose giving rise to the charge. Subject to the "Charges not Covered" and "Limitations" sections that follow, Covered Medical Charges include charges:
>
> . . .
>
> 7. For rehabilitative therapy by a licensed physical therapist, occupational therapist, speech therapist, vision therapist and cardiac/pulmonary therapist that is prescribed by a physician to restore function lost due to a covered illness or injury which occurs while You are insured.

John Alden's JIM.POL.CO (888) Max Plan, JIM.POL.CO (888) CoreMed, JIM.POL.CO (888) One Deductible Traditional and JIM.POL.CO (888) One Deductible PPO forms, stated in part:

> **BENEFIT SUMMARY**
>
> **POLICYHOLDER INFORMATION**

Therapies for Congenital Defects and Birth Abnormalities

Subject to Plan Deductible and Plan Coinsurance

Therapies for Congenital Defects and Birth Abnormalities includes up to 20 visits per Calendar Year for each physical, occupational, and speech therapy for Covered Dependent children *age 4 or younger*.

. . .

VII. MEDICAL BENEFITS

WE WILL PAY COVERED CHARGES ONLY FOR THE SERVICES AND SUPPLIES LISTED AS MEDICAL BENEFITS IN THIS SECTION OF THE PLAN. **HOW COVERED CHARGES ARE PAID AND THE MAXIMUM BENEFIT FOR COVERED SERVICES AND SUPPLIES LISTED IN THIS SECTION ARE SHOWN IN THE BENEFIT SUMMARY.**

. . .

Outpatient Physical Medicine Services

Services provided in the Outpatient department of an Acute Medical Facility, by a licensed therapist, or by a licensed or certified agency in a Covered Person's home on an Outpatient basis that includes, but are not limited to:

1. Physical Therapy, Occupational Therapy and Speech Therapy.

. . .

Coverage for Outpatient Physical medicine services will cease when measurable and significant progress toward expected and reasonable outcomes has been achieved or has plateaued as determined by US. [Emphases added.]

John Alden's 376 Right Start PPO, 376 Right Start w/Maternity, 376 Right Start HSA Traditional, 376 SaveRight PPO and 376 SaveRight Traditional forms, stated in part:

Covered Medical Services

Covered Medical Services include only Covered Charges for the services and supplies listed in this policy. Charges are subject to all the terms, limits and conditions of this plan. After you have paid any Deductible or Copayment, we will pay benefits for Covered Charges at the Rate of Payment up to the Out-of-Pocket limit and subject to the Calendar Year and Lifetime Maximum Benefit. [Emphasis added.]

Therapies for Congenital Defects And Birth Abnormalities: Benefits are payable after the first 31 days of life for Medically Necessary up to 20 visits per year each for physical, occupational, and speech therapy for the care and treatment of congenital defects and birth abnormalities for covered children *up to 5 years of age*. [Emphasis added.]

The following forms were not in compliance with Colorado insurance law:

Form Name	Date:
J-1104-C CO (BAS) Individual Health Benefit Conversion Policy	3/1995
CO.JA.BasicHD-CC Basic HSA Limited Mandate Health Benefit Plan	3/2006
CO.JA.Standard-CC Standard Health Benefit Plan	3/2006
Small Group J4000	No date
JIM.POL.CO Max Plan	No date
JIM.POL.CO CoreMed	01/1/09-09/30/09
JIM.POL.CO CoreMed	07/1/09-12/31/09
JIM.POL.CO One Deductible Traditional	No date
JIM.POL.CO One Deductible PPO	No date
JIM.POL.CO CoreMed w/Maternity	No date
376 Right Start PPO	No date
376 Right Start w/Maternity	No date
376 Right Start HSA Traditional	01/1/09-12/31/09
376 SaveRight PPO	01/01/09-12/31/09
376 SaveRight Traditional	01/1/09-12/31/09

Recommendation No. 4:

John Alden shall be provided a reasonable period, not exceeding thirty (30) days from the date of this report, to make written submission or rebuttal as to why it should not be considered in violation of § 10-16-104, C.R.S., and Colorado Emergency Insurance Regulation 08-E-12 and Amended Regulation 4-6-5. In the event John Alden is unable to provide such documentation, the Company may include, with its submission or rebuttal, its plan to comply, or documentation showing it is now in compliance.

Otherwise, John Alden shall be required, within sixty (60) days from the date this report is adopted, to provide written evidence to the Division that it has revised all applicable policy forms to reflect compliant benefits for physical, occupational and speech therapies, including therapies associated with congenital defects and birth abnormalities as required by Colorado insurance law. Within these sixty (60) days, John Alden shall also provide the Division with specimen copies of all revised policy forms containing compliant provisions for coverage of therapies and provide the proposed date that the forms will be put in use.

Issue E5: Failure, in some instances, to include accurate information in preferred provider organization (PPO) plan forms regarding preauthorization responsibility.

Section 10-16-705, C.R.S., Requirements for carrier and participating providers, states in part:

. . .

(14) Every contract between a carrier or entity that contracts with a carrier and a participating provider for a managed care plan that requires preauthorization for particular services, treatments, or procedures shall include:

(a) *A provision that clearly states that the sole responsibility for obtaining any necessary preauthorization rests with the participating provider that recommends or orders said services, treatments, or procedures, not with the covered person*; [Emphasis added.]

John Alden's health benefit plan forms, in some instances, were not in compliance with Colorado insurance law in that they required the member to contact John Alden for preauthorization instead of placing the burden on the contracted provider as statutorily required.

In addition, John Alden's forms indicated a penalty would be imposed on the insured if preauthorization was not requested and obtained for any service for which preauthorization was required. For example, John Alden's Form 888 CoreMed policy stated in part:

. . .

V. UTILIZATION REVIEW PROVISIONS

Utilization Review Process

THE COVERED PERSON *MUST CALL THE TOLL FREE NUMBER GIVEN ON THE IDENTIFICATION (ID) CARD TO OBTAIN OUR AUTHORIZATION FOR THE SERVICES LISTED UNDER THE WHEN TO CALL PROVISION IN THIS SECTION. BENEFITS WILL BE REDUCED AS DESCRIBED IN THE REDUCTION OF PAYMENT PROVISION IN THIS SECTION, IF A COVERED PERSON DOES NOT COMPLY WITH THIS UTILIZATION REVIEW PROCESS AND DOES NOT OBTAIN AUTHORIZATION.* [Emphasis added.]

The following forms were not in compliance with Colorado insurance law:

Form:	Date:
J-1104-C CO (BAS) Individual Health Benefit Conversion Policy	3/1995
Small Group J4000	No date
JIM.POL.CO Max Plan	No date
JIM.POL.CO CoreMed	01/1/09-
JIM.POL.CO CoreMed	07/1/09-12/31/09
JIM.POL.CO One Deductible PPO	No date
JIM.POL.CO CoreMed w/Maternity	No date
376 Right Start PPO	No date

376 Right Start w/Maternity	No date
376 SaveRight PPO	01/01/09-12/31/09
376 SaveRight Traditional	01/1/09-12/31/09

Recommendation No. 5:

John Alden shall be provided a reasonable period, not exceeding thirty (30) days from the date of this report, to make written submission or rebuttal as to why it should not be considered in violation of § 10-16-705, C.R.S. In the event John Alden is unable to provide such documentation, the Company may include, with its submission or rebuttal, its plan to comply, or documentation showing it is now in compliance.

Otherwise, John Alden shall be required, within sixty (60) days from the date this report is adopted, to provide written evidence to the Division that it has corrected all applicable forms to reflect that preauthorization, for those services that require it, is the sole responsibility of the contracted provider and that the covered person is to be held harmless for any lack of preauthorization on the part of the contracted provider as required by Colorado insurance law. Within these sixty (60) days, John Alden shall also provide the Division with specimen copies of all revised policy forms containing compliant preauthorization provisions and provide the proposed date that the forms will be put in use.

Issue E6: Failure, in some instances, to reflect correct or complete provisions of coverage for prosthetic devices in accordance with requirements of Colorado insurance law.

Section 10-16-104, C.R.S., Mandatory coverage provisions – definitions, states in part:

. . .

(14) Prosthetic devices.

(a) *Any health benefit plan, except supplemental policies covering a specified disease or other limited benefit, that provides hospital, surgical, or medical expense insurance shall provide coverage for benefits for prosthetic devices that equal those benefits provided for under federal laws for health insurance for the aged and disabled pursuant to 42 U.S.C. secs. 1395k, 1395l, and 1395m and 42 CFR 414.202, 414.210, 414.228, and 410.100, as applicable to this subsection (14).* [Emphasis added.]

(b) For the purposes of this subsection (14) "prosthetic device" means an artificial device to replace, in whole or in part, an arm or leg.

(c) A health benefit plan may require prior authorization for prosthetic devices in the same manner that prior authorization is required for any other covered benefit.

(d) Covered benefits are limited to the most appropriate model that adequately meets the medical needs of the patient as determined by the insured's treating physician.

(e) Repairs and replacements of prosthetic devices are also covered, subject to copayments and deductibles, unless necessitated by misuse or loss.

(f) A carrier may require that, if coverage is provided through a managed care plan, the benefits mandated pursuant to this subsection (14) shall be covered benefits only if the prosthetic devices are provided by a vendor and prosthetic services are rendered by a provider who contracts with or is designated by the carrier, to the extent that a carrier provides in-network and out-of-network services, the coverage for the prosthetic device shall be offered no less extensively.

Colorado Emergency Insurance Regulation 08-E-12 and Amended Regulation 4-6-5, Concerning Small Employer Group Basic and Standard Health Benefit Plans and The Basic and Standard Health Benefit Plans Policy Requirements for the State of Colorado, promulgated under the authority of §§ 10-1-109, 10-16-105(7.2), 10-16-108.5(8), and 10-16-109, C.R.S., state in part:*

*Emergency Regulation 08-E-12 (effective January 1, 2009) was replaced in its entirety by Amended Regulation 4-6-5, which was effective February 1, 2009. Other than the effective dates, the required benefits are identical for both regulations.

. . .

Section 2 Scope and Purpose

The purpose of the amendment to this regulation is to comply with the enactment of Senate Bill 08-057, which mandates coverage of hearing aids for children under the age of 18 and House Bill 08-1410, concerning the coverage of colorectal cancer prevention services. This regulation specifies the requirements for the basic and standard health benefit plans as well as other requirements for small employer carriers.

Section 3 Applicability

This regulation shall apply to all small employer carriers as defined in §10-16-102(41), C.R.S., and to all carriers required to provide conversion products pursuant to §10-16-108, C.R.S.

Section 4 Rules

A. Plans

1. Basic Plan. The form and content of the basic health benefit plan may be one or more of the three plan design options as appended to this regulation and shall constitute the basic health benefit plan design pursuant to §10-16-105(7.2), C.R.S. At least one of these three plan design options, two of which are high deductible, HSA-qualified plan options, shall be required for use in Colorado's small employer group market pursuant to §10-16-105(7.3), C.R.S., and as conversion coverage pursuant to §10-16-108, C.R.S. However, if the carrier chooses to offer more than one basic health benefit plan design, it shall offer all of its basic plan options to every small employer that expresses an interest in the basic health benefit plan or to those individuals purchasing a basic conversion plan.

2. Standard Plan. The form and content of the standard health benefit plan, as appended to this regulation, shall constitute the standard health benefit plan required for use in Colorado's small employer group market pursuant to §10-16-105(7.3), C.R.S., and for use as conversion coverage pursuant to §10-16-108, C.R.S.

BASIC AND STANDARD HEALTH BENEFIT PLAN
POLICY REQUIREMENTS FOR THE STATE OF COLORADO

Colorado Division of Insurance
Effective January 1, 2009

1. The basic health benefit plan as defined by the Commissioner pursuant to §10-16-105(7.2)(b), C.R.S., for an indemnity, preferred provider organization (PPO), and health maintenance organization (HMO) plan shall include the specific benefits and coverages outlined in one of the attached tables labeled "Basic

Limited Mandate Health Benefit Plan", "Basic HSA Health Benefit Plan", or "Basic HSA Limited Mandate Health Benefit Plan".

2. The standard health benefit plan for an indemnity, PPO, and HMO plan shall include the specific benefits and coverages outlined in the attached table labeled "Standard Health Benefit Plan".

JANUARY 1, 2009 COLORADO BASIC LIMITED MANDATE HEALTH BENEFIT PLANS:

INDEMNITY, PPO

PART B: SUMMARY OF BENEFITS

(Please note: all coinsurance percentages listed are what the carrier will pay for service.)

	BASIC INDEMNITY PLAN	BASIC PPO PLAN	
BASIC LIMITED MANDATE HEALTH BENEFIT PLAN		**IN-NETWORK**	**OUT-OF-NETWORK**
22. DURABLE MEDICAL EQUIPMENT [17]	50% coinsurance $1,000/year maximum	70% coinsurance	50% coinsurance
		$1,000/year maximum (In-network deductible applies to network providers and the out-of-network deductible applies to out-of-network providers. However, the maximum benefit is combined for in-network and out-of-network benefits.)	

[17] Coverage for lesser of purchase or rental price for medically necessary durable medical equipment. DME includes, but is not limited to, home-administered oxygen and reusable equipment for the treatment of diabetes. The cost of prosthetics does not apply to the annual DME maximum. The benefit level for prosthetic devices for arms or legs or parts thereof shall be as required by §10-16-104(14), C.R.S. Repair or replacement of defective equipment is covered at no additional charge; repair and replacement needed because of normal usage is covered, but repair and replacement needed due to misuse/abuse by the insured is ***not*** covered.

JANUARY 1, 2009 COLORADO BASIC HSA LIMITED MANDATE HEALTH BENEFIT PLANS:

INDEMNITY, PPO

PART B: SUMMARY OF BENEFITS

(Please note: all coinsurance percentages listed are what the carrier will pay for the service.)

	BASIC INDEMNITY PLAN	BASIC PPO PLAN	
Basic HSA Limited Mandate Health Benefit Plan		**IN-NETWORK**	**OUT-OF-NETWORK**
22. DURABLE MEDICAL EQUIPMENT [16]	50% coinsurance $1,000/year maximum	70% coinsurance	50% coinsurance
		$1,000/year maximum (In-network deductible applies to network providers and the out-of-network deductible applies to out-of-network providers. However, the maximum benefit is combined for in- and out-of-network benefits.)	

[16] Coverage for lesser of purchase or rental price for medically necessary durable medical equipment. DME includes, but is not limited to, home-administered oxygen and reusable equipment for the treatment of diabetes. The cost of prosthetics does not apply to the annual DME maximum. The benefit level for prosthetic devices for arms or legs or parts thereof shall be as required by §10-16-104(14), C.R.S. Repair or replacement of defective equipment is covered at no additional charge; repair and replacement needed because of normal usage is covered, but repair and replacement needed due to misuse/abuse by the insured is ***not*** covered.

JANUARY 1, 2009 COLORADO STANDARD HEALTH BENEFIT PLANS: INDEMNITY, PPO

PART B: SUMMARY OF BENEFITS

(Please note: all coinsurance percentages listed are what the carrier will pay for service).

		STANDARD PPO PLAN	
	STANDARD INDEMNITY PLAN	**IN-NETWORK**	**OUT-OF-NETWORK [2]**
22. DURABLE MEDICAL EQUIPMENT [21]	80% coinsurance $2,000/year maximum	80% coinsurance	50% coinsurance
		$2,000/year maximum (In-network deductible applies to network providers and the out-of-network deductible applies to out-of-network providers. However, the maximum benefit is combined for in-network and out-of-network benefits.)	

[21] Coverage for lesser of purchase or rental price for medically necessary durable medical equipment. DME includes, but is not limited to, home-administered oxygen and reusable equipment for the treatment of diabetes. The cost of prosthetics does not apply to the annual DME maximum. The benefit level for prosthetic devices for arms or legs or parts thereof shall be as required by §10-16-104(14), C.R.S. Repair or replacement of defective equipment is covered at no additional charge; repair and replacement needed because of normal usage is covered, but repair and replacement needed due to misuse/abuse by the insured is ***not*** covered.

John Alden was not in compliance with Colorado insurance law in that its Individual Health Benefit Conversion Policy [Basic Limited Mandate Health Benefit Plan]; Basic HSA Limited Mandate Health Benefit Plan; and Standard Health Benefit Plan forms failed to reflect accurate coverage of Durable Medical Equipment – Prosthetics, as required by Colorado Insurance Regulation 4-6-5.

In addition, John Alden's limitations in forms regarding prosthetics were overly restrictive in that the regulation provides that the cost of prosthetics does not apply to the annual DME maximum and the benefits for prosthetic devices for arms or legs (or any part thereof) are mandated by § 10-16-104(14), C.R.S. Further, repair or replacement of defective equipment is to be covered at no additional charge; and any repair and replacement needed because of normal usage is required to be covered. The regulation does not provide for a five year usage, five years of coverage under a plan of insurance, or five year replacement program. Additionally, the co-insurance and benefit maximum, in some instances, failed to reflect benefits as described in the respective tables of Colorado Insurance Regulation 4-6-5. Finally, coverage of prosthetic devices to replace an arm or leg cannot be restricted to only a loss while insured.

John Alden's individual medical plan forms were not in compliance with Colorado insurance law in that the forms failed to provide for prosthetic devices as required by § 10-16-104(14), C.R.S., by limiting coverage to the temporary interim and initial permanent basic artificial limb, and included the cost of such prosthetics under the plans' DME maximum. In addition, the forms failed, in some instances, to reflect provisions for the most appropriate model that adequately meets the medical needs of the patient as determined by the insured's treating physician.

John Alden's Individual Health Benefit Conversion Policy [Basic Limited Mandate Health Benefit Plan] form stated in part:

> **Covered Medical Charges**
>
> Covered Medical Charges must be Medically Necessary and incurred by You, or Your Insured Dependent, while insured. A charge is deemed incurred as of the date of the service, treatment or purchase giving rise to the charge. Subject to the "Charges Not Covered" and "Limitations" sections that follow, Covered Medical Charges include charges:
>
> . . .
>
> 9. for the rental, up to but not to exceed the purchase price, of durable medical equipment, to include:
>
> . . .
>
> *d. Other durable medical equipment which would be approved as a covered item by Medicare standards;* [Emphasis added.]
>
> For an Insured Person's personal and exclusive use, *except that repair or replacement of damaged equipment* and duplicate equipment rentals *will not be considered Covered Medical Charges.* [Emphasis added.]

John Alden's Basic HSA Limited Mandate Health Benefit Plan states in part:

> . . .
>
> **V. MEDICAL EQUIPMENT, SUPPLIES, AND PROSTHESES**
>
> **We will cover charges:**
>
> *1. For the first temporary fitting and first permanent purchase of artificial limbs,* larynx, eyes or other Prostheses, *but only if required for the replacement of natural parts of the body lost while insured.*
>
> 2. For the replacement of Prostheses that have been outgrown due to normal skeletal growth and/or wear and tear, *but only after the insured has had the Prostheses for at least [5] years, has been continuously covered under this plan for at least [5] years, and only on a [5] year replacement basis thereafter.* [Emphases added.]
>
> **For regular PPO plan**
>
> Benefits for medical equipment, supplies and prostheses are subject to a [$1,000] maximum per year. In-network deductible applies to network providers and the out-of-network deductible applies to non-network providers. However, the maximum benefit is combined for in- and out-of-network benefits.
>
> **For indemnity plan**

Benefits for medical equipment, supplies and prostheses are subject to a [$1,000] maximum per year.

We will not cover charges:

. . .

2. For any of the following:
a. Equipment maintenance;
b. *Repair or replacement of damaged equipment,* except for prosthetic devices;
c. Duplicate equipment rentals and purchases;
d. Motorized wheelchairs that would not be allowed by Medicare;
e. *Replacement of equipment that has been outgrown due to other than normal skeletal growth;* [Emphasis added.]

John Alden's Standard Health Benefit Plan form states in part:

. . .

V. MEDICAL EQUIPMENT, SUPPLIES, AND PROSTHESES

We will cover charges:

. . .

2. *For the first temporary fitting and first permanent purchase of artificial limbs,* larynx, eyes or other Prostheses, *but only if required for the replacement of natural parts of the body lost while insured.*
3. For the replacement of Prostheses that have been outgrown due to normal skeletal growth and/or wear and tear, *but only after the insured has had the Prostheses for at least [5] years, has been continuously covered under this plan for at least [5] years, and only on a [5] year replacement basis thereafter.* [Emphasis added.]

Benefits for durable medical equipment are paid at [80%] after satisfaction of the Annual Deductible up to a [$2,000] maximum benefit per year.

We will not cover charges:

. . .

2. For any of the following:
a. Equipment maintenance;
b. *Repair or replacement of damaged equipment,* except for prosthetic devices;
c. Duplicate equipment rentals and purchases;
d. Motorized wheelchairs that would not be allowed by Medicare;
e. *Replacement of equipment that has been outgrown due to other than normal skeletal growth;* [Emphasis added.]

John Alden's JIM.POL.CO (888) Max Plan, JIM.POL.CO (888) CoreMed, JIM.POL.CO (888) One Deductible Traditional and JIM.POL.CO (888) One Deductible PPO forms state in part:

VII. MEDICAL BENEFITS

WE WILL PAY COVERED CHARGES ONLY FOR THE SERVICES AND SUPPLIES LISTED AS MEDICAL BENEFITS IN THIS SECTION OF THE PLAN. **HOW COVERED CHARGES ARE PAID AND THE MAXIMUM BENEFIT FOR COVERED SERVICES AND SUPPLIES LISTED IN THIS SECTION ARE SHOWN IN THE BENEFIT SUMMARY.**

. . .

Durable Medical Equipment and Personal Medical Equipment

. . .

3. The temporary interim and initial permanent basic artificial limb or eye. [Emphasis added.]

John Alden's 376 Right Start PPO, 376 Right Start w/Maternity, 376 Right Start HSA Traditional, 376 SaveRight PPO and 376 SaveRight Traditional forms state in part:

Covered Medical Services

Covered Medical Services include only Covered Charges for the services and supplies listed in this policy. Charges are subject to all the terms, limits and conditions of this plan. After you have paid any Deductible or Copayment, we will pay benefits for Covered Charges at the Rate of Payment up to the Out-of-Pocket limit and subject to the Calendar Year and Lifetime Maximum Benefit.

. . .

Supplies and Durable Medical Equipment for the lesser of the rental or purchase price. This coverage is limited to: [Emphasis in original.]

- *Basic prosthetic devices*; [Emphasis added.]

The following forms were not in compliance with Colorado insurance law:

Form:	Date:
J-1104-C CO (BAS) Individual Health Benefit Conversion Policy	3/1995
CO.JA.BasicHD-CC Basic HSA Limited Mandate Health Benefits Plan	3/2006
CO.JA.Standard-CC Standard Health Benefits Plan	3/2006
Small Group J4000	No date
JIM.POL.CO Max Plan	No date
JIM.POL.CO CoreMed	01/1/09-09/30/09
JIM.POL.CO CoreMed	07/1/09-12/31/09
JIM.POL.CO One Deductible Traditional	No date
JIM.POL.CO One Deductible PPO	No date
JIM.POL.CO CoreMed w/Maternity	No date
376 Right Start PPO	No date
376 Right Start w/Maternity	No date

376 Right Start HSA Traditional	01/1/09-12/31/09
376 SaveRight PPO	01/01/09-12/31/09
376 SaveRight Traditional	01/1/09-12/31/09

Recommendation No. 6:

John Alden shall be provided a reasonable period, not exceeding thirty (30) days from the date of this report, to make written submission or rebuttal as to why it should not be considered in violation of §10-16-104, C.R.S., and Colorado Emergency Insurance Regulations 08-E-12 and Amended Regulation 4-6-5. In the event John Alden is unable to provide such documentation, the Company may include, with its submission or rebuttal, its plan to comply, or documentation showing it is now in compliance.

Otherwise, John Alden shall be required, within sixty (60) days from the date this report is adopted, to provide written evidence to the Division that it has corrected all applicable forms to reflect correct coverage for prosthetic devices as required by Colorado insurance law. Within these sixty (60) days, John Alden shall also provide the Division with specimen copies of all revised policy forms containing compliant provisions for coverage of prosthetic devices and provide the proposed date that the forms will be put in use.

Issue E7: Failure of the Company's forms, in some instances, to include correct coverage to be provided for home health services as required by Colorado insurance law.

Section 10-16-104, C.R.S., Mandatory coverage provisions – definitions, states in part:

. . .

8) Availability of hospice care coverage.

(a) As used in this subsection (8), unless the context otherwise requires:

(I) "Home health services" means home health services as defined in section 25.5-4-103 (7), C.R.S., which are provided by a home health agency certified by the department of public health and environment.

. . .

(b) Notwithstanding any other provision of the law to the contrary, no individual or group policy of sickness and accident insurance issued by an insurer subject to the provisions of part 2 of this article and no plan issued by an entity subject to the provisions of part 3 of this article which provides hospital, surgical, or major medical coverage on an expense incurred basis shall be sold in this state unless a policyholder under such policy or plan is offered the opportunity to purchase coverage for benefits for the costs of home health services and hospice care which have been recommended by a physician as medically necessary. Nothing in this paragraph (b) shall require an insurer to offer coverages for which premiums would not cover expected benefits. This paragraph (b) shall not apply to any insurance policy, plan, contract, or certificate which provides coverage exclusively for disability loss of income, dental services, optical services, hospital confinement indemnity, accident only, or prescription drug services.

(c) The insurer or entity may adopt standards and criteria for eligibility to be applied to home health services programs and hospice care programs consistent with standards established in rules and regulations of the department of public health and environment.

(d) The commissioner, in consultation with the department of public health and environment, may establish by rule and regulation requirements for standard policy and plan provisions which state clearly and completely the criteria for and extent of insured coverage for home health services and hospice care. Such provisions shall be designed to facilitate prompt and informed decisions regarding patient placement and discharge.

Colorado Insurance Regulation 4-2-8 Concerning Required Health Insurance Benefits For Home Health Services And Hospice Care promulgated under the authority of §§ 10-1-109 and 10-16-1 04(8)(d), C.R.S., states in part:

. . .

Section 2. Purpose

The purpose of this regulation is to establish requirements for standard policy provisions, *which state clearly and completely the criteria for and extent of coverage for home health services* and hospice care and to facilitate prompt and informed decisions regarding patient placement and discharge. [Emphasis added.]

Section 3. Scope

The requirements of this regulation shall apply to:

A. Insurers subject to the provisions of Part 2 of Article 16 of Title 10, C.R.S. and non-profit hospital, medical surgical, and health service corporations subject to the provisions of Part 3 of Article 16 of Title 10, C.R.S., which provide: hospital, surgical or major medical coverage on an expense incurred basis, except as noted in paragraph B below, issued on or after the effective date hereof and to all such policies renewed after said date, unless the insurer certifies in writing to the Commissioner of Insurance that it no longer issues the type of policy being renewed. "Renewed" or "renewal" means to continue coverage for an additional policy period upon expiration of the current policy period of a policy.

B. This regulation does not apply to the following:

(1) Medicare supplement policies issued under § 10-18-101 et seq., C.R.S.;

(2) Credit accident and health policies issued under § 10-10-101 et seq., C.R.S.; and

(3) Any insurance policy, contracts or certificate which provides coverage exclusively for:

(a) Disability loss of income;
(b) Dental services;
(c) Optical services;
(d) Hospital confinement indemnity;
(e) Accident only; or
(f) Prescription drug services.

Section 4. Requirements for Home Health Services

A. Definitions.

(1) "Home health agency" means an agency which has been certified by the Colorado Department of Public Health and Environment as meeting the provisions of Title XVIII of the Federal "Social Security Act", as amended, for home health agencies and which is engaged in arranging and providing nursing services, home health aide services and other therapeutic and related services.

(2) "Home health services" means the following services provided by a certified home health agency under a plan of care to eligible persons in their place of residence:

(a) Professional nursing services;
(b) Certified nurse aide services, as defined in § 12-38.1-102(3), C.R.S.;
(c) Medical supplies, equipment and appliances suitable for use in the home; and
(d) Physical therapy, occupational therapy or speech pathology and audiology services, as such therapy and services are defined in C.R.S.

(3) "Home health visit" is each visit by a member of the home health team, provided on a part-time and intermittent basis as included in the plan of care. *Services of up to 4 hours by a home health aide shall be considered as one visit.* [Emphasis added.]

(4) "Medical social services" are those services provided by an individual who possesses a baccalaureate degree in social work, psychology or counseling or the documented equivalent in a combination of education, training and experience, which services are provided at the recommendation of a physician for the purpose of assisting the insured or the family in dealing with a specific medical condition.

B. General Policy Provisions Pertaining to Home Health Care.

(1) *The policy offering shall provide that home health services are to be covered when such services are necessary as alternatives to hospitalization or in place of hospitalization.* Prior hospitalization shall not be required.

(2) *The policy offering shall require, as a condition of coverage that home health care services are to be rendered pursuant to a physician's written order, under a plan of care established by the physician in collaboration with a home health care provider.*

(3) The policy offering may use case management requirements including, but not limited to, authorization of benefits prior to the beginning of services, review of treatment at periodic intervals *and certification by the physician that confinement in a hospital or skilled nursing facility would be required in the absence of home health services.* [Emphases added.]

(4) The policy may require that all home health services included in the plan of care be coordinated by the home health agency.

C. Benefits for Home Health Care Services.

(1) Benefits levels for home health care services shall not be less than the deductible, coinsurance and stop loss provisions of the overall policy or certificate.

(2) *The policy or certificate may contain a limitation on the number of home health visits, but no policy offered may provide for fewer than 60 home health visits in any calendar year*. [Emphasis added.]

(3) The policy offered shall include benefits for the following services:

(a) Professional nursing services provided by a Registered Nurse;
(b) Certified nurse aide services under the supervision of a Registered Nurse or a qualified therapist;
(c) Physical therapy;
(d) Occupational therapy;
(e) Speech therapy and audiology;
(f) Respiratory and inhalation therapy;
(g) Nutrition counseling by a nutritionist or dietitian;
(h) Medical social services;
(i) Medical supplies;
(j) Prosthesis and orthopedic appliances;
(k) Rental or purchase of durable medical equipment; and
(l) Drugs, medicines, or insulin.

(4) The services identified in (C)(3)(i) through (C)(3)(l) above may be included elsewhere in the policy, rather than specifically in the home health benefit provisions.

D. Limitations and Exclusions.

(1) Benefits for home health services may be governed by policy or certificate limitations and exclusions, including but not limited to, exclusion for non-skilled personal care and conditions for surgery excluded in the policy or certificate.

(2) The following items need not be considered as eligible expenses under home health care benefits:

(a) Services or supplies for personal comfort or convenience, including homemaker services;
(b) Services related to well-baby care; and Food services or meals other than dietary counseling.

Colorado Emergency Insurance Regulation 08-E-12 and Amended Regulation 4-6-5, Concerning Small Employer Group Basic and Standard Health Benefit Plans and The Basic and Standard Health Benefit Plans Policy Requirements for the State of Colorado, promulgated under the authority of §§ 10-1-109, 10-16-105(7.2), 10-16-108.5(8), and 10-16-109, C.R.S., state in part:*

*Emergency Regulation 08-E-12 (effective January 1, 2009) was replaced in its entirety by Amended Regulation 4-6-5, which was effective February 1, 2009. Other than the effective dates, the required benefits are identical for both regulations.

. . .

Section 2 Scope and Purpose

The purpose of the amendment to this regulation is to comply with the enactment of Senate Bill 08-057, which mandates coverage of hearing aids for children under the age of 18 and House Bill 08-1410, concerning the coverage of colorectal cancer prevention services. This regulation specifies the requirements for the basic and standard health benefit plans as well as other requirements for small employer carriers.

Section 3 Applicability

This regulation shall apply to all small employer carriers as defined in §10-16-102(41), C.R.S., and to all carriers required to provide conversion products pursuant to §10-16-108, C.R.S.

Section 4 Rules

A. Plans

1. Basic Plan. The form and content of the basic health benefit plan may be one or more of the three plan design options as appended to this regulation and shall constitute the basic health benefit plan design pursuant to §10-16-105(7.2), C.R.S. At least one of these three plan design options, two of which are high deductible, HSA-qualified plan options, shall be required for use in Colorado's small employer group market pursuant to §10-16-105(7.3), C.R.S., and as conversion coverage pursuant to §10-16-108, C.R.S. However, if the carrier chooses to offer more than one basic health benefit plan design, it shall offer all of its basic plan options to every small employer that expresses an interest in the basic health benefit plan or to those individuals purchasing a basic conversion plan.

2. Standard Plan. The form and content of the standard health benefit plan, as appended to this regulation, shall constitute the standard health benefit plan required for use in Colorado's small employer group market pursuant to §10-16-105(7.3), C.R.S., and for use as conversion coverage pursuant to §10-16-108, C.R.S.

BASIC AND STANDARD HEALTH BENEFIT PLAN
POLICY REQUIREMENTS FOR THE STATE OF COLORADO

Colorado Division of Insurance
Effective January 1, 2009

1. The basic health benefit plan as defined by the Commissioner pursuant to §10-16-105(7.2)(b), C.R.S., for an indemnity, preferred provider organization (PPO), and health maintenance organization (HMO) plan shall include the specific benefits and coverages outlined in one of the attached tables labeled "Basic Limited Mandate Health Benefit Plan", "Basic HSA Health Benefit Plan", or "Basic HSA Limited Mandate Health Benefit Plan".

2. The standard health benefit plan for an indemnity, PPO, and HMO plan shall include the specific benefits and coverages outlined in the attached table labeled "Standard Health Benefit Plan".

JANUARY 1, 2009 COLORADO BASIC LIMITED MANDATE HEALTH BENEFIT PLANS:

INDEMNITY, PPO

PART B: SUMMARY OF BENEFITS

(Please note: all coinsurance percentages listed are what the carrier will pay for service.)

<table>
<tr><th></th><th>BASIC INDEMNITY PLAN</th><th colspan="2">BASIC PPO PLAN</th></tr>
<tr><th>BASIC LIMITED MANDATE HEALTH BENEFIT PLAN</th><th></th><th>IN-NETWORK</th><th>OUT-OF-NETWORK[2]</th></tr>
<tr><td rowspan="2">25. HOME HEALTH CARE [18a]</td><td rowspan="2">50% coinsurance
Limited to 60 visits per year</td><td>70% coinsurance</td><td>50% coinsurance</td></tr>
<tr><td colspan="2">Limited to 60 visits per year combined maximum</td></tr>
</table>

[2] Out-of-network cost sharing (deductibles, coinsurance, and out-of-pocket maximums) levels apply ***ONLY IF*** plan has network providers for the covered benefit and insured/member goes out of the network. Otherwise, in-network levels apply.

[18a] Covered services are defined in Colorado Insurance Regulation 4-2-8.

JANUARY 1, 2009 COLORADO BASIC HSA LIMITED MANDATE HEALTH BENEFIT PLANS:

INDEMNITY, PPO

PART B: SUMMARY OF BENEFITS

(Please note: all coinsurance percentages listed are what the carrier will pay for the service.)

	BASIC INDEMNITY PLAN	**BASIC PPO PLAN**	
Basic HSA Limited Mandate Health Benefit Plan		**IN-NETWORK**	**OUT-OF-NETWORK[1a]**
25. HOME HEALTH CARE [16a]	50% coinsurance Limited to 60 visits per year	70% coinsurance	50% coinsurance
		Limited to 60 visits per year combined maximum	

[1a] Out-of-network cost sharing (deductibles, coinsurance, and out-of-pocket maximums) levels apply *ONLY IF* plan has network providers for the covered benefit and insured/member goes out of the network. Otherwise, in-network-levels apply.

[16a] Covered services are defined in Colorado Insurance Regulation 4-2-8.

JANUARY 1, 2009 COLORADO STANDARD HEALTH BENEFIT PLANS: INDEMNITY, PPO

PART B: SUMMARY OF BENEFITS

(Please note: all coinsurance percentages listed are what the carrier will pay for service).

		STANDARD PPO PLAN	
	STANDARD INDEMNITY PLAN	**IN-NETWORK**	**OUT-OF-NETWORK[2]**
25. **HOME HEALTH CARE** [22a]	80% coinsurance	80% coinsurance	

[2] Out-of-network cost sharing (deductibles, coinsurance, and out-of-pocket maximums) levels apply ***ONLY IF*** plan has network providers for the covered benefit and insured/member goes out of the network. Otherwise, in-network-levels apply.

[22a] Covered services are defined in Colorado Insurance Regulation 4-2-8.

John Alden was not in compliance with Colorado insurance law in that its Individual Health Benefit Conversion Policy [Basic Limited Mandate Health Benefit Plan]; Basic HSA Limited Mandate Health Benefit Plan; and Standard Health Benefit Plan forms failed to provide accurate information regarding home health care services as required by Colorado Insurance Regulations 4-2-8 and 4-6-5. The cited regulations have specific requirements for home health care services, which John Alden's forms failed to meet in certain areas. For example, the Basic Limited Mandate Health Benefit Plan reflected an essentially correct definition of home health care services. However, the information provided under the contract's covered benefits section regarding home health care services merely stated that it will cover such services or supplies as provided under the terms of a Home Health Care Plan. The definition of a home health care plan did not mention services and supplies, a health care agency or health care aide. Further, John Alden's definition and the description in the covered benefits section failed to provide any information regarding coinsurance or annual limits on visits for home care.

The Basic HSA Limited Mandate Health Benefit Plan form included a definition of home health care services, but, instead of advising the limits of coinsurance or annual visits, it stated it will not cover any Home Health Care services or supplies.

The Standard Health Benefit Plan form failed to provide any information regarding coinsurance requirements and merely advised that benefits would not exceed the Usual, Customary and Reasonable amount for such service.

The individual Colorado Standard PPO plan form failed to provide any information regarding the general policy provisions pertaining to home health care or the benefits for home health care services as required by Colorado Insurance Regulation 4-2-8.

The individual health plan forms, 376 Right Start PPO, 376 Right Start w/Maternity, 376Right Start HSA Traditional [01/1/09-12/31/09], 376 SaveRight PPO [01/01/09-12/31/09], and 376 SaveRight Traditional, failed to advise that certification by the physician for confinement in a hospital or skilled nursing facility would be required in the absence of home health care services.

The individual health plan forms, 888 JIM.POL.CO Max Plan, 888 JIM.POL.CO CoreMed, 888 JIM.POL.CO CoreMed, 888 JIM.POL.CO One Deductible Traditional, and 888 JIM.POL.COOne Deductible PPO, failed to provide accurate information regarding home health care services in the following ways: The benefits summary page provided that there is a maximum annual benefit of 240 hours or 60 visits per Covered Person. While this is mathematically correct, it failed to provide that each visit can be up to 4 hours as stated in Regulation 4-2-8. A shorter visit uses up one of the 60 visits and thereby reduces the number of remaining hours available for home health care. The medical benefits section incorrectly stated, "one visit consists *of up to 2 hours* of care within a 24-hour period by anyone providing services or evaluating the need for Home Health Care." This limitation contradicted the Benefit Summary in that 2 hours times 60 visits amounts to only 120 hours versus the stated benefit of "240 hours or 60 visits".

The language in John Alden's Basic Limited Mandate Health Benefit Plan (Individual Health Benefit Conversion Policy) form stated in part:

DEFINITIONS

. . .

Home Health Aide means a person, other than a registered nurse (R.N.), who provides medical and therapeutic care under the supervision of a Home Health Care Agency.

Home Health Care Agency means an agency licensed as a Home Health Care Agency or an agency operated by state or local government which provides home health care services in the home, through its employees.

Home Health Care Plan is a plan that meets these tests:

1. it must be a formal written plan made by the patient's attending Physician; and
2. it must certify that the home health care is in place of Hospital Confinement; and
3. it must specify the type and extent of home health care required for the treatment of the patient.

Home Health Care Services means the following services and supplies:

1. part-time or intermittent nursing care by or under the supervision of a registered nurse (RN). Private-duty shift nursing is not considered a Home Health Care Service or Supply.
2. part-time or intermittent home health aide services provided through a Home Health Care Agency. This does not include general housekeeping services.
3. physical, occupational, respiratory and speech therapy.
4. medical supplies.
5. laboratory services by or on behalf of the Hospital.

Note: A person who provides services as a nurse, therapist or Home Health Aide may not:

a. normally live in the Insured's home; or
b. be a Close Relative of the Insured.

COVERED MEDICAL CHARGES

And

CHARGES NOT COVERED

. . .

15. for Home Health Care Services in connection with Home Health Care by a Home Health Care Agency to the extent such services or supplies are provided under the terms of a Home Health Care Plan.

The language in John Alden's Basic HSA Limited Mandate Preferred Provider Benefit Summary stated in part:

SECTION I: DEFINITIONS

. . .

Home Health Agency

An agency licensed as a Home Health Agency or an agency operated by state or local government which provides in the home, through its employees, the following services in the home:

1. part-time or intermittent skilled nursing services provided by a Registered Nurse or Licensed Vocational Nurse;
2. part-time or intermittent home health aide services which provide supportive services in the home under the supervision of a Registered Nurse or a physical, speech or occupational therapist;
3. physical, occupational or speech therapy; and
4. medical supplies, drugs and medicines prescribed by a Physician and related pharmaceutical services, and laboratory services to the extent such charges or costs would be covered under the plan if the insured person was confined in a hospital.

Home Health Care

Home Health services by a Home Health Agency for the care and treatment of an insured person who is under the direct care and supervision of a Physician but only if:

1. hospitalization would otherwise be required if home health care were not provided; and
2. a home health care treatment plan is established, in writing, and approved by a Physician.

COVERED MEDICAL CHARGES

And

CHARGES NOT COVERED

. . .

We will not cover charges:

. . .

7. *For any Home Health Care services or supplies.* [Emphasis added.]

COVERED MEDICAL CHARGES

And

CHARGES NOT COVERED

. . .

PROVIDER AND FACILITY CHARGES

We will cover charges:

. . .

10. Made by a Home Health Agency for Home Health Care services in connection with a Home Health Care plan of treatment approved by Us, but not to exceed the Usual, Customary and Reasonable amount for such service.

The language in John Alden's individual Colorado Standard PPO, stated in part:

Covered Medical Charges

. . .

15. for Home Health Care Services in connection with Home Health Care by a Home Health Care Agency to the extent such services or supplies are provided under the terms of a Home Health Care Plan.

The language in John Alden's individual health plans: 376 Right Start PPO, 376 Right Start w/Maternity, 376Right Start HSA Traditional [01/1/09-12/31/09], 376 SaveRight PPO [01/01/09-12/31/09], and 376 SaveRight Traditional, stated in part:

Home Health Care Services provided by a home health care agency up to 60 home health visits each calendar year by a state-licensed nurse, respiratory therapist, and services included in a preauthorized Health Care Practioner's plan of treatment (including nutrition counseling and medical social services). A home health visit is each visit by a member of the home health team, provided on a part-time and intermittent basis as included in the plan of care. Services up to 4 hours by a home health aide are considered 1 visit.

The language in John Alden's individual health plans: 888 JIM.POL.CO Max Plan, 888 JIM.POL.CO CoreMed, 888 JIM.POL.CO CoreMed, 888 JIM.POL.CO One Deductible Traditional, and 888 JIM.POL.CO One Deductible PPO, stated in part:

BENEFIT SUMMARY
POLICYHOLDER INFORMATION

Home Health Care Services:

Subject to Plan deductible and Plan Coinsurance
Benefits are limited to a Maximum Calendar Year benefit of 240 hours or 60 visits per Covered Person. [Emphasis added.]

. . .

VII. MEDICAL BENEFITS

. . .

Home Health Care must be provided by a Home Health Care Agency. *One visit consists of up to 2 hours of care within a 24-hour period* by anyone providing

> services or evaluating the need for Home Health Care. Services must be included in a plan of treatment established by a Health Care Practitioner. [Emphasis added.]

The following forms were not in compliance with Colorado insurance law:

Form:		Date:
J-1104-C CO (BAS)	Individual Health Benefit Conversion Policy	3/1995
CO.JA.BasicHD-CC	Basic HSA Limited Mandate Health Benefit Plan	3/2006
CO.JA.Standard-CC	Standard Health Benefit Plan	3/2006
JIM.POL.CO Max Plan		No date
JIM.POL.CO CoreMed		01/1/09-09/30/09
JIM.POL.CO CoreMed		07/1/09-12/31/09
JIM.POL.CO One Deductible Traditional		No date
JIM.POL.CO One Deductible PPO		No date
JIM.POL.CO CoreMed w/Maternity		No date
376 Right Start PPO		No date
376 Right Start w/Maternity		No date
376 Right Start HAS Traditional		01/1/09-12/31/09
376 SaveRight PPO		01/01/09-12/31/09
376 SaveRight Traditional		01/1/09-12/31/09

Recommendation No. 7:

John Alden shall be provided a reasonable period, not exceeding thirty (30) days from the date of this report, to make written submission or rebuttal as to why it should not be considered in violation of § 10-16-104, C.R.S., and Colorado Insurance Regulations 4-2-8, Emergency Regulation 08-E-12 and Amended Regulation 4-6-5. In the event John Alden is unable to provide such documentation, the Company may include, with its submission or rebuttal, its plan to comply, or documentation showing it is now in compliance.

Otherwise, John Alden shall be required, within sixty (60) days from the date this report is adopted, to provide written evidence to the Division that it has revised all applicable forms to reflect the mandatory coverage for home health care services required by Colorado insurance law. Within these sixty (60) days, John Alden shall also provide the Division with specimen copies of all revised policy forms containing compliant provisions for coverage of home health care service and the proposed date that the forms will be put in use.

Issue E8: Failure of the Company's forms, in some instance, to provide accurate information regarding payment of claims after preauthorization or approval for services.

Section 10-16-704, C.R.S., Network Adequacy, states in part:

> . . .
>
> (4) *When a treatment or procedure has been preauthorized by the plan, benefits cannot be retrospectively denied except for fraud and abuse.* If a health carrier provides preauthorization for treatment or procedures that are not covered benefits under the plan, the carrier shall provide the benefits as authorized with no penalty to the covered person. [Emphasis added.]

Colorado Division of Insurance Bulletin No. B-4.13 Preauthorization for Treatments or Procedures by Health Plans issued May 8, 2007, states in part:

> **I. Background and Purpose**
>
> Carriers often contract with third party to perform medical necessity or utilization review. The results of these reviews are often provided to the insureds or their providers before the carrier has made its coverage determination. In an attempt to reserve the right to make a subsequent coverage determination, the initial notification sometimes contains disclaimer language stating that coverage is contingent upon a subsequent level of review. After notification of approval at the initial review for medical necessity, some carriers are later denying coverage for the treatment or procedure which was the subject of the initial approval.
>
> . . .
>
> **III. Division Position**
>
> Colorado law states that once a carrier has "preauthorized" a treatment or procedure, the carrier cannot retrospectively deny the treatment or procedure, except for fraud and abuse, even where the benefit is not covered under the plan. See § 10-16-704(4), C.R.S. In addition, the statute prohibits the carrier from imposing a penalty on the insured for coverage of the benefit where the treatment or procedure was preauthorized. Covered persons and providers often do not distinguish between a medical necessity determination and a coverage determination, and act upon the initial medical necessity determination alone.
>
> *To avoid any confusion between the types of determination, the Division interprets this statute to mean that whenever a treatment or procedure is approved, irrespective of the terminology used by the carrier when reviewing the claim (e.g., precertification, preauthorization, medical necessity or utilization review), the carrier cannot subsequently deny coverage. In other words, it is incumbent upon the carrier to make its coverage determination prior to the delivery of any medical necessity determination* or other form of preauthorization to the covered person or their provider. The exceptions are for fraud and abuse or where the insured loses coverage after approval, but before actually obtaining the treatment or procedure. In addition, the carrier cannot reduce the benefit which was subject to the initial review in any manner, such as by requiring the insured to pay a higher co-pay than would normally be due under the plan. [Emphasis added.]

> Carriers cannot avoid the statutory requirement by including a disclaimer in the notice initially approving the treatment or procedure. For example, a carrier cannot notify a provider and or insured that a particular treatment or procedure has passed a certain level of review, but final approval is contingent upon additional review. To do so is a violation of the intent of the statute to prohibit retrospective denials after "preauthorization."

John Alden was not in compliance with Colorado insurance law in that its policy language in some cases, implied that the claim could be retrospectively denied for reasons other than those provided for in § 10-16-704(4), C.R.S.

As an example of John Alden's language concerning preauthorization in its policies, The CorMed policy on page 35 stated the following:

> ***A REVIEW BY THE MEDICAL REVIEW MANAGER DOES NOT GUARANTEE THAT BENEFITS WILL BE PAID.*** **PAYMENT OF BENEFITS WILL BE SUBJECT TO ALL THE TERMS, LIMITS AND CONDITIONS IN THIS POLICY.** [Emphasis added.]

The following forms were not in compliance with Colorado insurance law:

Form/Plan:		Date:
J-1104-C CO (BAS)	Individual Health Benefit Conversion Policy	3/1995
CO.JA.BasicHD-CC	Basic HSA Limited Mandate Health Benefits Plan	3/2006
CO.JA.Standard-CC	Standard Health Benefits Plan	3/2006
Small Group J4000		No date
JIM.POL.CO Max Plan		No date
JIM.POL.CO CoreMed		01/1/09-09/30/09
JIM.POL.CO CoreMed		07/1/09-12/31/09
JIM.POL.CO One Deductible PPO		No date
JIM.POL.CO CoreMed w/Maternity		No date
376 Right Start PPO		No date
376 Right Start w/Maternity		No date
376 SaveRight PPO		01/01/09-12/31/09

Recommendation No. 8:

John Alden shall be provided a reasonable period, not exceeding thirty (30) days from the date this report, to make written submission or rebuttal as to why it should not be considered in violation of § 10-16-704, C.R.S. In the event John Alden is unable to provide such documentation, the Company may include, with its submission or rebuttal, its plan to comply, or documentation showing it is now in compliance.

Otherwise, John Alden shall be required, within sixty (60) days from the date this report is adopted, to provide written evidence to the Division that it has revised all applicable forms to reflect the correct provisions for the payment of pre-authorized services as required by Colorado insurance law. Within these sixty (60) days, John Alden shall also provide the Division with specimen copies of all revised policy forms containing compliant payment of pre-authorized services provisions and the proposed date that the forms will be put in use.

Issue E9: Failure of the Company's forms, in some instance, to provide notification of the availability of conversion to a Basic or Standard Health Benefit Plan to an employee, dependent or member upon termination of group coverage.

Section 10-16-108, C.R.S., Conversion and continuation privileges, states in part:

(1) Group sickness and accident insurance – conversion privileges.

. . .

(c)(I) *A group policy delivered or issued for delivery in this state which provides hospital, surgical, or major medical expense insurance or any combination of these coverages on an expense-incurred basis*, but not including a policy which provides benefits for specific diseases or for accidental injuries only, *shall provide* that an employee, dependent, or member whose insurance under the group policy has been terminated for any reason other than discontinuance of the group policy in its entirety or with respect to an insured class or failure of the employee or member to pay any required contribution and who has been continuously insured under the group policy (and under any group policy providing similar benefits which it replaces) for at least three months immediately prior to termination is entitled to have issued by the insurer *a policy of sickness and accident insurance, referred to in this paragraph (c) as the "converted policy",* subject to the following conditions:…[Emphasis added.]

. . .

(d)(I) A converted policy issued upon the exercise of the conversion privilege of paragraph (c) of this subsection (1) *shall offer a choice of a basic or standard health benefit plan.* [Emphasis added.]

John Alden's Basic HSA Limited Mandate and Standard group policy forms were not in compliance with Colorado insurance law in that they did not provide the mandated notification of availability to convert to an individual basic or standard health benefit plan to an employee, dependent or member upon termination of their coverage under the group plan.

Form:		Date:
CO.JA.BasicHD-CC	Basic HSA Limited Mandate Health Benefit Plan for Colorado	3/2006
CO.JA.Standard-CC	Standard Health Benefits Plan for Colorado	3/2006

Recommendation No. 9:

John Alden shall be provided a reasonable period, not exceeding thirty (30) days from the date this report, to make written submission or rebuttal as to why it should not be considered in violation of § 10-16-108, C.R.S. In the event John Alden is unable to provide such documentation, the Company may include, with its submission or rebuttal, its plan to comply, or documentation showing it is now in compliance.

Otherwise, John Alden shall be required, within sixty (60) days from the date this report is adopted, to provide written evidence to the Division that it has revised all applicable forms to reflect notification of the availability of conversion to a basic or standard health benefit plan as required by Colorado insurance law. Within these sixty (60) days, John Alden shall also provide the Division with specimen copies of all revised policy forms containing compliant notice of the availability of conversion to a basic or standard plan and the proposed date that the forms will be put in use.

Issue E10: Failure of the Company's Basic and Standard Health Benefit Plan forms to reflect the correct lifetime or benefit maximums in accordance with Colorado insurance law.

Colorado Emergency Insurance Regulation 08-E-12 and Amended Regulation 4-6-5, Concerning Small Employer Group Basic and Standard Health Benefit Plans and The Basic and Standard Health Benefit Plans Policy Requirements for the State of Colorado, promulgated under the authority of §§ 10-1-109, 10-16-105(7.2), 10-16-108.5(8), and 10-16-109, C.R.S. state in part:*

*Emergency Regulation 08-E-12 (effective January 1, 2009) was replaced in its entirety by Amended Regulation 4-6-5, which was effective February 1, 2009. Other than the effective dates, the required benefits are identical for both regulations.

. . .

Section 2 Scope and Purpose

The purpose of the amendment to this regulation is to comply with the enactment of Senate Bill 08-057, which mandates coverage of hearing aids for children under the age of 18 and House Bill 08-1410, concerning the coverage of colorectal cancer prevention services. This regulation specifies the requirements for the basic and standard health benefit plans as well as other requirements for small employer carriers.

Section 3 Applicability

This regulation shall apply to all small employer carriers as defined in §10-16-102(41), C.R.S., and to all carriers required to provide conversion products pursuant to §10-16-108, C.R.S.

Section 4 Rules

A. Plans

1. Basic Plan. The form and content of the basic health benefit plan may be one or more of the three plan design options as appended to this regulation and shall constitute the basic health benefit plan design pursuant to §10-16-105(7.2), C.R.S. At least one of these three plan design options, two of which are high deductible, HSA-qualified plan options, shall be required for use in Colorado's small employer group market pursuant to §10-16-105(7.3), C.R.S., and as conversion coverage pursuant to §10-16-108, C.R.S. However, if the carrier chooses to offer more than one basic health benefit plan design, it shall offer all of its basic plan options to every small employer that expresses an interest in the basic health benefit plan or to those individuals purchasing a basic conversion plan.

2. Standard Plan. The form and content of the standard health benefit plan, as appended to this regulation, shall constitute the standard health benefit plan required for use in Colorado's small employer group market pursuant to §10-16-105(7.3), C.R.S., and for use as conversion coverage pursuant to §10-16-108, C.R.S.

BASIC AND STANDARD HEALTH BENEFIT PLAN
POLICY REQUIREMENTS FOR THE STATE OF COLORADO

Colorado Division of Insurance
Effective January 1, 2009

1. The basic health benefit plan as defined by the Commissioner pursuant to §10-16-105(7.2)(b), C.R.S., for an indemnity, preferred provider organization (PPO), and health maintenance organization (HMO) plan shall include the specific benefits and coverages outlined in one of the attached tables labeled "Basic Limited Mandate Health Benefit Plan", "Basic HSA Health Benefit Plan", or "Basic HSA Limited Mandate Health Benefit Plan".

2. The standard health benefit plan for an indemnity, PPO, and HMO plan shall include the specific benefits and coverages outlined in the attached table labeled "Standard Health Benefit Plan".

JANUARY 1, 2009 COLORADO BASIC LIMITED MANDATE HEALTH BENEFIT PLANS:

INDEMNITY, PPO

PART B: SUMMARY OF BENEFITS

(Please note: all coinsurance percentages listed are what the carrier will pay for service.)

	BASIC INDEMNITY PLAN	**BASIC PPO PLAN**	
BASIC LIMITED MANDATE HEALTH BENEFIT PLAN		**IN-NETWORK**	**OUT-OF-NETWORK**
6. LIFETIME OR BENEFIT MAXIMUM PAID BY THE PLAN FOR ALL CARE	$ 2 million	$ 5 million	

JANUARY 1, 2009 COLORADO BASIC HSA LIMITED MANDATE HEALTH BENEFIT PLANS:

INDEMNITY, PPO

PART B: SUMMARY OF BENEFITS

(Please note: all coinsurance percentages listed are what the carrier will pay for the service.)

	BASIC INDEMNITY PLAN	BASIC PPO PLAN	
Basic HSA Limited Mandate Health Benefit Plan		**IN-NETWORK**	**OUT-OF-NETWORK**
6. LIFETIME OR BENEFIT MAXIMUM PAID BY THE PLAN FOR ALL CARE	$ 2 million	$ 5 million	

JANUARY 1, 2009 COLORADO STANDARD HEALTH BENEFIT PLANS:

INDEMNITY, PPO

PART B: SUMMARY OF BENEFITS

(Please note: all coinsurance percentages listed are what the carrier will pay for service).

		STANDARD PPO PLAN	
	STANDARD INDEMNITY PLAN	**IN-NETWORK**	**OUT-OF-NETWORK [2]**
6. LIFETIME OR BENEFIT MAXIMUM PAID BY THE PLAN FOR ALL CARE	$ 2 million	$ 5 million	

John Alden was not in compliance with Colorado insurance law in that its Individual Health Benefit Conversion Policy [Basic Limited Mandate Health Benefit Plan]; Basic HSA Limited Mandate Health Benefit Plan; and, Standard Health Benefit Plan forms failed to provide the correct Lifetime or Benefit Maximums paid for by the plans as required by Colorado Insurance Regulation 4-6-5.

The language in John Alden's Individual Health Benefit Conversion Policy [Basic Limited Mandate Health Benefit Plan] form stated in part:

> **Lifetime Maximum Benefit**
>
> *The maximum amount of Major Medical Benefits payable to an Insured Person or on his or her behalf during his or her lifetime is [$1,000,000]* as shown on the benefit summary. This limit applies to You and each of Your Insured Dependents, separately, while insured under this plan, even if coverage is interrupted. If at the end of the Year, the maximum has been reduced by benefits paid during the Year, the maximum that remains will be increased on the first day of the next year by the lesser of: [Emphasis added.]
>
> . . .
>
> d. $5,000; or

e. The amount needed to restore the entire maximum.

The language in John Alden's Basic HSA Limited Mandate Indemnity Benefit Summary states in part:

SCHEDULE OF MEDICAL BENEFITS

Major Medical Benefits for [Single Plan/Family Plan/Employee-Spouse Plan/Employee-Child Plan].

LIFETIME MAXIMUM BENEFIT: ***$1,000,000*** [Emphasis added.]

The language in John Alden's Basic HSA Limited Mandate Preferred Provider Benefit Summary states in part:

SCHEDULE OF MEDICAL BENEFITS

Major Medical Benefits for [Single Plan/Family Plan/Employee-Spouse Plan/Employee-Child Plan].

	IN-NETWORK	**OUT-OF-NETWORK**
LIFETIME MAXIMUM BENEFIT:	***$2,000,000***	***$2,000,000*** [Emphasis added.]

The language in John Alden's Standard Health Benefit Plan form states in part:

SCHEDULE OF MEDICAL BENEFITS

Major Medical Benefits for [Single Plan/Family Plan/Employee-Spouse Plan/Employee-Children Plan].

LIFETIME MAXIMUM BENEFIT: ***$1,000,000*** [Emphasis added.]

The following forms were not in compliance with Colorado insurance law:

Form:		Date:
J-1104-C CO (BAS)	Individual Health Benefit Conversion Policy [Basic Limited Mandate Health Benefits Plan]	3/1995
CO.JA.BasicHD-CC	Basic HSA Limited Mandate Health Benefits Plan	3/2006
CO.JA.Standard-CC	Standard Health Benefits Plan	3/2006

Recommendation No. 10:

John Alden shall be provided a reasonable period, not exceeding thirty (30) days from the date this report, to make written submission or rebuttal as to why it should not considered in violation of Colorado Emergency Insurance Regulation 08-E-12 and Amended Regulation 4-6-5. In the event John Alden is unable to provide such documentation, the Company may include, with its submission or rebuttal, its plan to comply, or documentation showing it is now in compliance.

Otherwise, John Alden shall be required, within sixty (60) days from the date this report is adopted, to provide written evidence to the Division that it has revised all applicable forms to reflect lifetime and/or benefit maximums as required by Colorado insurance law. Within these sixty (60) days, John Alden shall also provide the Division with specimen copies of all revised policy forms containing compliant provisions for lifetime and/or benefit maximums and the proposed date that the forms will be put in use.

Issue E11: Failure of the Company's forms, in some instances, to include provisions for coverage of early intervention services.

Section 10-16-104, C.R.S., Mandatory coverage provisions – definitions, states in part:

. . .

(1.3) Early intervention services.

. . .

(b) (I) *All individual and group sickness and accident insurance policies issued by an entity subject to part 2 of this article on or after January 1, 2008, and all service or indemnity contracts issued by an entity subject to part 3 or 4 of this article on or after January 1, 2008, that include dependent coverage shall provide coverage for early intervention services delivered by a qualified early intervention service provider to an eligible child.* Early intervention services specified in an eligible child's IFSP shall qualify as meeting the standard for medically necessary health care services as used by private health insurance plans. [Emphasis added.]

(II) The coverage required by this subsection (1.3) shall be available annually to an eligible child from birth up to the child's third birthday and shall be limited to five thousand seven hundred twenty-five dollars, including case management costs, for early intervention services for each dependent child per calendar or policy year. For policies or contracts issued or renewed on or after January 1, 2009, and on or after each January 1 thereafter, the limit shall be adjusted by the division based on the consumer price index for the Denver-Boulder-Greeley metropolitan statistical area for the state fiscal year that ends in the preceding calendar year.

(III) Except as provided in paragraph (d) of this subsection (1.3), the coverage shall not be subject to deductibles or copayments, and any benefits paid under the coverage required by this subsection (1.3) shall not be applied to an annual or lifetime maximum benefit contained in the policy or contract. Unless the carrier agrees prior to the provision of early intervention services, a carrier shall not be required to pay a reimbursement rate for early intervention services provided by a nonparticipating provider that exceeds the reimbursement rate allowed for comparable early intervention services provided by a participating provider.

John Alden was not in compliance with Colorado insurance law in that the Company's policy forms, in some instances, did not contain provisions for coverage of early intervention services for children up to three years of age.

The following forms were not in compliance with Colorado insurance law:

Form/Plan:		Date:
J-1104-C CO (BAS)	Individual Health Benefit Conversion Policy	3/1995
CO.JA.BasicHD-CC	Basic HSA Limited Mandate Health Benefits Plan	3/2006
CO.JA.Standard-CC	Standard Health Benefits Plan	3/2006
Small Group J4000		No date
JIM.POL.CO Max Plan		No date
JIM.POL.CO CoreMed		01/1/09-09/30/09
JIM.POL.CO CoreMed		07/1/09-12/31/09
JIM.POL.CO One Deductible Traditional		No date
JIM.POL.CO One Deductible PPO		No date
JIM.POL.CO CoreMed w/Maternity		No date
376 Right Start PPO		No date
376 Right Start w/Maternity		No date
376 Right Start HAS Traditional		01/1/09-12/31/09
376 SaveRight PPO		01/01/09-12/31/09
376 SaveRight Traditional		01/1/09-12/31/09

Recommendation No. 11:

John Alden shall be provided a reasonable period, not exceeding thirty (30) days from the date of this report, to make written submission or rebuttal as to why it should not be considered in violation of § 10-16-104, C.R.S. In the event John Alden is unable to provide such documentation, the Company may include, with its submission or rebuttal, its plan to comply, or documentation that it is now in compliance.

Otherwise, John Alden shall be required, within sixty (60) days from the date this report is adopted, to provide written evidence to the Division that it has revised all applicable forms to reflect the mandatory coverage for early intervention services as required by Colorado insurance law. Within these sixty (60) days, John Alden shall also provide the Division with specimen copies of all revised policy forms containing compliant provisions for coverage of early intervention services and the proposed date that the forms will be put in use.

Issue E12: Failure of the Company's forms, in some instances, to reflect a complying definition of a preexisting condition under Colorado insurance law.

Section 10-16-118, C.R.S., Limitations on preexisting condition limitations, states in part:

> (1) A health coverage plan that covers residents of this state:
>
> (a) (I) If it is a *group health benefit plan*, shall not deny, exclude, or limit benefits for a covered individual because of a preexisting condition for losses incurred more than *six* months following the date of enrollment of the individual in such plan or, if earlier, the first day of the waiting period for such enrollment; except that, for business groups of one, a health benefit plan shall not deny, exclude, or limit benefits for a covered individual because of a preexisting condition for losses incurred more than twelve months following the date of enrollment of the individual in such plan. A group health benefit plan may impose a preexisting condition exclusion or limitation *only* if such exclusion relates to a condition (whether physical or mental), regardless of the cause of the condition, for which medical advice, diagnosis, care, or treatment was recommended or received within six months immediately preceding the date of enrollment of the individual in such plan or, if earlier, the first day of the waiting period for such enrollment; except that a group health benefit plan shall not impose any preexisting condition exclusion in the case of a child that is adopted or placed for adoption before attaining eighteen years of age, or relating to pregnancy. [Emphasis added.]
>
> (II) If it is an individual health benefit plan, or a group health coverage plan to which subparagraph (I) of this paragraph (a) does not apply, shall not deny, exclude, or limit benefits for a covered individual because of a preexisting condition for losses incurred more than twelve months following the effective date of coverage and may not define a preexisting condition more restrictively than an injury, sickness, or pregnancy for which a person incurred charges, received medical treatment, consulted a health care professional, or took prescription drugs within twelve months.

John Alden was not in compliance with Colorado insurance law in that its policy forms, in some instances contained a definition of a preexisting condition that was more restrictive than allowed by Colorado insurance law. The definition of a preexisting condition in these forms was more restrictive in that it excluded coverage for a twelve (12)-month period for group plans. Group plans other than Business Groups of One, may only be limited for preexisting conditions for six (6) months. John Alden's definition of preexisting condition in its Basic and Standard health benefit plan forms was more restrictive in that it excluded coverage regardless of whether or not the covered individual had received any medical advice, diagnosis or treatment prior to the enrollment date.

John Alden's group benefit plan forms (other than the Basic and Standard Plans) defined a preexisting condition as follows:

> **Pre-Existing Condition**

> A Sickness or an Injury and related complications for which medical advice, consultation, diagnosis, care or treatment was sought, received or recommended from a provider or Prescription Drugs were prescribed *during the 12-month period* immediately prior to the Covered Person's Effective Date, *regardless of whether the condition was diagnosed, misdiagnosed or not diagnosed.* [Emphasis added.]

John Alden's Basic and Standard Plan forms contained the following definition of a preexisting condition:

> **Pre-Existing Condition (Applies to Medical Benefits only)**
>
> Any Illness (whether physical or mental) or Injury present during the six (6) months just before Your or Your Dependent's enrollment for medical benefits under this policy *whether or not any medical advice, diagnosis, care or treatment was recommended or received before the Enrollment Date.* [Emphasis added.]

The following forms were not in compliance with Colorado insurance law:

Form/Plan:		Date:
STM 146.001		07-2005
J-1104-C CO (BAS)	Individual Health Benefit Conversion Policy	3/1995
CO.JA.BasicHD-CC	Basic HSA Limited Mandate Health Benefits Plan	3/2006
CO.JA.Standard-CC	Standard Health Benefits Plan	3/2006
Small Group J4000		No date
JIM.POL.CO Max Plan		No date
JIM.POL.CO CoreMed		01/1/09-09/30/09
JIM.POL.CO CoreMed		07/1/09-12/31/09
JIM.POL.CO One Deductible Traditional		No date
JIM.POL.CO One Deductible PPO		No date
JIM.POL.CO CoreMed w/Maternity		No date
376 Right Start PPO		No date
376 Right Start w/Maternity		No date
376 Right Start HAS Traditional		01/1/09-12/31/09
376 SaveRight PPO		01/01/09-12/31/09
376 SaveRight Traditional		01/1/09-12/31/09

Recommendation No. 12:

John Alden shall be provided a reasonable period, not exceeding thirty (30) days from the date of this report, to make written submission or rebuttal as to why it should not be considered in violation of § 10-16-118, C.R.S. In the event John Alden is unable show such documentation, the Company may include, with its submission or rebuttal, its plan to comply, or documentation showing it is now in compliance

Otherwise, John Alden shall be required, within sixty (60) days from the date this report is adopted, to provide written evidence to the Division that it has revised all applicable forms to reflect the correct definition of pre-existing conditions as required by Colorado insurance law. Within these sixty (60) days, John Alden shall also provide the Division with specimen copies of all revised policy forms containing compliant provisions for the definition of pre-existing conditions and the proposed date that the forms will be put in use.

Issue E13: Failure of the Company's forms, in some instances, to reflect correct reasons for termination of coverage.

Section 10-16-201.5, C.R.S., Renewability of health benefit plans – modification of health benefit plans, states in part:

> (1) A carrier providing coverage under a health benefit plan shall not discontinue coverage or refuse to renew such plan *except for the following reasons*: [Emphasis added.]
>
> (a) Nonpayment of the required premium:
>
> (b) Fraud or intentional misrepresentation of material fact on the part of the plan sponsor with respect to group health benefit plan coverage and the individual with respect to individual coverage;
>
> . . .
>
> (d)(I) The carrier elects to discontinue offering and nonrenew all of its individual, small group, or large group health benefit plans delivered or issued for delivery in this state;
>
> . . .
>
> (f) With respect to individual health benefit plans, the commissioner finds that the continuation of the coverage would not be in the best interest of the policyholders or certificate holders, the plan is obsolete, or would impair the carrier's ability to meet its contractual obligations.
>
> . . .
>
> (4) *An individual health benefit plan must clearly disclose in its contracts and marketing materials the conditions of renewability which conform with the requirements of this section.* [Emphasis added.]

John Alden's individual policies were not in compliance with Colorado insurance law in that in some instances, an unacceptable reason for termination of coverage was reflected. Moving out of the service area is not a valid reason for terminating coverage on an individual plan.

John Alden's individual health plans define the circumstances in which a policy can be terminated as follows:

> **IV. EFFECTIVE DATE AND TERMINATION DATE**
>
> This policy will terminate at 12:01 a.m. local time at the Policyholder's state of residence on the earliest of the following dates:
>
> The date We receive a request in writing or by telephone to terminate this plan or on a later date that is requested by the Policyholder for termination.
>
> 1. The date We receive a request in writing or by telephone to terminate coverage for a Covered Dependent or on a later date that is

requested by the Policyholder for termination of a Covered Dependent.

2. The date this plan lapses for nonpayment of premium per the Grace Period provision in the Premium Provisions section.

3. The date there is fraud or material misrepresentation made by or with the knowledge of any Covered Person applying for this coverage or filing a claim for benefits.

4. The date all policies with the same form number are non-renewed in the state in which this policy was issued or the state in which the Policyholder presently resides.

5. The date We terminate or nonrenew health insurance coverage in the individual market in the state in which this policy was issued or the state in which You presently reside. We will give You advance notice, as required by state law, of the termination of Your coverage.

6. The date the Policyholder moves to a state where We do not provide individual medical insurance coverage.

7. *The date a Covered Person moves outside of the Service Area if he or she has a PPO plan.*[Emphasis added.]

The following policy forms were not in compliance with Colorado insurance law:

Form/Plan	Date
JIM.POL.CO Max Plan	No date
JIM.POL.CO CoreMed	01/1/09-09/30/09
JIM.POL.CO CoreMed	07/1/09-12/31/09
JIM.POL.CO One Deductible Traditional	No date
JIM.POL.CO One Deductible PPO	No date
JIM.POL.CO CoreMed w/Maternity	No date

Recommendation No. 13:

John Alden shall be provided as reasonable period, not exceeding thirty (30) days from the date this report, to make submission or rebuttal why it should not be considered in violation of § 10-16-201.5, C.R.S. In the event John Alden is unable to show such documentation, the Company may include, with its submission or rebuttal, its plan to comply, or documentation showing it is now in compliance.

Otherwise, John Alden shall be required, within sixty (60) days from the date this report is adopted, to provide written evidence to the Division that it has revised all applicable forms to reflect the correct reasons for termination of coverage as required by Colorado insurance law. Within these sixty (60) days, John Alden shall also provide the Division with specimen copies of all revised policy forms containing compliant reasons for termination of coverage and the proposed date that the forms will be put in use.

Issue E14: Failure of the Company's forms, in some instances, to reflect correct information regarding requests for Independent External Reviews.

Section 10-16-113.5, C.R.S., Independent external review of benefit denials-legislative declaration-definitions, states in part:

. . .

6) All health coverage plan materials dealing with the plan's grievance procedures shall advise covered persons in writing of the availability of an independent external review process, the circumstances under which a covered individual requesting an independent external review may use the independent external review process, the procedures for requesting an independent external review, and the deadlines associated with an independent external review.

Colorado Insurance Regulation 4-2-21, External Review Of Benefit Denials Of Health Coverage Plans, promulgated under the authority of §§ 10-1-109, 10-16-109, 10-16-113(3)(b) and 10-16-113.5(4)(d), C.R.S., states in part:

. . .

Section 5 Notice and Disclosure of Right to External Review

. . .

B. Disclosure requirements.

1. *Effective for policies issued or renewed on or after June 1, 2000, each carrier shall include a description of the external review procedures in or attached to all health coverage plan materials dealing with the plan's grievance procedures including but not limited to the policy, certificate, membership booklet, outline of coverage or other evidence of coverage it provides to covered persons.* [Emphasis added.]

2. The description required under Paragraph 1. of this Subsection B. shall include a notification of the availability of an external review process, the circumstances under which a covered person may use the external review process, the procedures for requesting an external review, and the timelines associated with an external review.

. . .

Section 7 Exhaustion of Internal Appeal Process

A request for an external review pursuant to Section 8 or 9 of this regulation may be made after the covered person has received the carrier's decision *following the first level or second level review of an adverse determination* as set forth in Colorado Insurance Regulation 4-2-17. [Emphasis added.]

John Alden was not in compliance with Colorado insurance law in that the description of when an independent external review could be requested was incorrect.

John Alden's policy forms stated the following under the section of Independent External Review Requests:

1. *You have exhausted the internal appeals process and are still dissatisfied.* [Emphasis added.]

The insured or their representatives are not required to go through the entire appeals process before filing an Independent External Review.

The following policy forms were not in compliance with Colorado insurance law:

Form/Plan:		Date:
J-1104-C CO (BAS)	Individual Health Benefit Conversion Policy	3/1995
CO.JA.BasicHD-CC	Basic HSA Limited Mandate Health Benefits Plan	3/2006
CO.JA.Standard-CC	Standard Health Benefits Plan	3/2006
Small Group J4000		No date
JIM.POL.CO Max Plan		No date
JIM.POL.CO CoreMed		01/1/09-09/30/09
JIM.POL.CO CoreMed		07/1/09-12/31/09
JIM.POL.CO One Deductible Traditional		No date
JIM.POL.CO One Deductible PPO		No date
JIM.POL.CO CoreMed w/Maternity		No date
376 Right Start PPO		No date
376 Right Start w/Maternity		No date
376 Right Start HAS Traditional		01/1/09-12/31/09
376 SaveRight PPO		01/01/09-12/31/09
376 SaveRight Traditional		01/1/09-12/31/09

Recommendation No. 14:

John Alden shall be provided a reasonable period, not exceeding thirty (30) days from the date of this report, to make written submission or rebuttal as to why it should not be considered in violation of § 10-16-113.5 C.R.S. and Colorado Insurance Regulation 4-2-21. In the event John Alden is unable to show such documentation, the Company may include with its submission or rebuttal its plan to comply, or documentation showing it is in compliance.

Otherwise, John Alden shall be required, within sixty (60) days from the date this report is adopted, to provide written evidence to the Division that it has revised all applicable forms to reflect correct information with regard to requesting independent external reviews as required by Colorado insurance law. Within these sixty (60) days, John Alden shall also provide the Division with specimen copies of all revised policy forms containing compliant information regarding the request for an independent external review and the proposed date that the forms will be put in use.

Issue E15: Failure of the Company's forms, in some instances, to offer dependent coverage up to twenty-five years of age.

Section 10-16-104.3, C.R.S., Dependent health coverage for persons under twenty-five years of age, states in part:

> (1) *All individual* and group *sickness and accident insurance policies* providing coverage within the state by an entity subject to the provisions of part 2 of this article and all group health service contracts issued by an entity subject to the provisions of part 3 or 4 of this article that offer dependent coverage *shall offer to the parent,* for an additional premium if applicable, *by rider or supplemental policy provision,* the same dependent *coverage for an unmarried child who is under twenty-five years of age,* and is not a dependent as defined by section 10-16-102 if such child: [Emphasis added.]
>
> (2) The additional premium, if applicable, for a rider or supplemental policy provision offered pursuant to subsection (1) of this section, shall be paid by the parent or the policyholder, at the discretion of the policyholder.

John Alden was not in compliance with Colorado insurance law in that the Company forms, in some instances, restricted dependent coverage in their individual health benefit plan forms to twenty-four (24) years of age, and did not offer to provide coverage for an unmarried child under twenty-five years of age by rider or supplemental policy provision.

John Alden's 376 series or Right Start policies described dependent coverage as follows:

> **Covered Dependent**
>
> The policyholder's lawful spouse or an unmarried child who is under the age of 19 and either a natural child, a child legally adopted or placed for adoption, or a stepchild.
>
> - *If an unmarried child under the age of 24* and financially dependent upon the parent, the child will be considered a Covered Dependent if you submit proof that the child meets the standards for a full time student at an accredited educational institution. *The student will be considered a Covered Dependent until the student is no longer a full time student, is no longer financially dependent upon the parent, graduates, attains age 24, or marries, whichever occurs first.* [Emphasis added.]

Form/Plan:	Date:
376 Right Start PPO	No date
376 Right Start w/Maternity	No date
376 Right Start HAS Traditional	01/1/09-12/31/09
376 SaveRight PPO	01/01/09-12/31/09
376 SaveRight Traditional	01/1/09-12/31/09

Recommendation No. 15:

John Alden shall be provided a reasonable period, not exceeding thirty (30) days from the date of this report, to make written submission or rebuttal as to why it should not be considered in violation of § 10-16-104.3, C.R.S. In the event John Alden is unable to show such documentation, the Company may include, with its submission or rebuttal, its plan to comply, or documentation showing it is now in compliance.

Otherwise, John Alden shall be required, within sixty (60) days from the date this report is adopted, to provide written evidence to the Division that it has revised all applicable forms to reflect the correct age limits for dependent coverage as required by Colorado insurance law. Within these sixty (60) days, John Alden shall also provide the Division with specimen copies of all revised policy forms containing compliant provisions for dependent coverage and the proposed date that the forms will be put in use.

Issue E16: Failure of the Company's forms, in some instances, to reflect coverage provisions for colorectal cancer screenings.

Section 10-16-104, C.R.S., Mandatory coverage provisions-definitions, states in part:

. . .

(18) **Preventive health care services.**

(a) (I) Except as specified in subparagraph (II) of this paragraph (a), the following policies and contracts that are delivered, issued, renewed, or reinstated on or after July 1, 2009, shall provide coverage for the total cost of the preventive health care services specified in paragraph (b) of this subsection (18):

(A) All individual and all group sickness and accident insurance policies, except supplemental policies covering a specified disease or other limited benefit, that are delivered or issued for delivery within the state by an entity subject to the provisions of part 2 of this article;

(B) All individual and group health care service or indemnity contracts issued by an entity subject to the provisions of part 3 or 4 of this article; and

(C) Any other individual or group health care coverage offered to residents of this state.

(II) Nothing in this subsection (18) shall be deemed to apply to a basic health benefit plan issued pursuant to section 10-16-105 (7.2) (b) (I), (7.2) (b) (III), or (7.2) (b) (IV).

(III) Coverage shall not be subject to policy deductibles. Copayments and coinsurance may apply. For a health maintenance organization that directly provides health care services to its enrollees, the policy deductibles, copayments, coinsurance, and any other form of cost sharing for the total costs associated with the coverage required by this subsection (18) shall not exceed ten percent of the cost of the preventive health care service required by this subsection (18).

(b) The coverage required by this subsection (18) shall include coverage for the tests specified in subparagraph (II) of this paragraph (b) for the early detection of colorectal cancer and adenomatous polyps for those covered persons who are specified in subparagraph (I) of this paragraph (b):

(I) Asymptomatic, average risk adults who are fifty years of age or older and covered persons who are at high risk for colorectal cancer, including covered persons who have a family medical history of colorectal cancer; a prior occurrence of cancer or precursor neoplastic polyps; a prior occurrence of a chronic digestive disease

condition such as inflammatory bowel disease, Crohn's disease, or ulcerative colitis; or other predisposing factors as determined by the provider;

(II) The following tests as determined by the provider that detect adenomatous polyps or colorectal cancer: Modalities that are currently included in an A recommendation or a B recommendation by the task force.

(c) For purposes of this subsection (18):

(I) "A recommendation" means a recommendation adopted by the task force that strongly recommends that clinicians provide a preventive health care service for the early detection of colorectal cancer or adenomatous polyps to eligible patients because the task force:

(A) Found good evidence that the preventive health care service improves important health outcomes; and

(B) Concluded that the benefits of the preventive health care service substantially outweigh its harms.

(II) "B recommendation" means a recommendation adopted by the task force that recommends that clinicians provide a preventive health care service for the early detection of colorectal cancer or adenomatous polyps to eligible patients because the task force:

(A) Found at least fair evidence that the preventive health care service improves important health outcomes; and

(B) Concluded that the benefits of the preventive health care service outweigh its harms.

(III) "Task force" means the U.S. preventive services task force, or any successor organization, sponsored by the agency for healthcare research and quality, the health services research arm of the federal department of health and human services.

(d) The health care service plan issued by an entity subject to the provisions of part 4 of this article may provide that the benefits provided pursuant to this subsection (18) shall be covered benefits only if the services are rendered by a provider who is designated by and affiliated with the health maintenance organization.

John Alden’s individual health benefit plan forms, in some instances, were not in compliance with Colorado insurance law in that they did not reflect coverage for the mandated coverage of colorectal cancer screening as required under Colorado insurance law.

The following forms were not in compliance with Colorado insurance law:

Form/Plan:	Date:
Small Group J4000	No date
JIM.POL.CO Max Plan	No date
JIM.POL.CO CoreMed	01/1/09-09/30/09
JIM.POL.CO CoreMed	07/1/09-12/31/09
JIM.POL.CO One Deductible Traditional	No date
JIM.POL.CO One Deductible PPO	No date
JIM.POL.CO CoreMed w/Maternity	No date
376 Right Start PPO	No date
376 Right Start w/Maternity	No date
376 Right Start HAS Traditional	01/1/09-12/31/09
376 SaveRight PPO	01/01/09-12/31/09
376 SaveRight Traditional	01/1/09-12/31/09

Recommendation No. 16:

John Alden shall be provided a reasonable period, not exceeding thirty (30) days from the date of this report, to provide written submission or rebuttal as to why it should not be considered in violation of § 10-16-104, C.R.S. In the event John Alden is unable to show such documentation, the Company may include, with its submittal or rebuttal, its plan to comply, or documentation showing it is now in compliance.

Otherwise, John Alden shall be required, within sixty (60) days from the date this report is adopted, to provide written evidence to the Division that it has revised all applicable forms to reflect the mandatory coverage for colorectal cancer screening as required by Colorado insurance law. Within these sixty (60) days, John Alden shall also provide the Division with specimen copies of all revised policy forms containing compliant provisions for coverage of colorectal cancer screening and the proposed date that the forms will be put in use.

Issue E17: Failure of the Company's forms, in some instances, to provide accurate information related to out-of-pocket annual maximums.

Colorado Emergency Insurance Regulation 08-E-12 and Amended Regulation 4-6-5, Concerning Small Employer Group Basic and Standard Health Benefit Plans and The Basic and Standard Health Benefit Plans Policy Requirements for the State of Colorado, promulgated under the authority of §§ 10-1-109, 10-16-105(7.2), 10-16-108.5(8), and 10-16-109, C.R.S., state in part:*

*Emergency Regulation 08-E-12 (effective January 1, 2009) was replaced in its entirety by Amended Regulation 4-6-5, which was effective February 1, 2009. Other than the effective dates, the required benefits are identical for both regulations.

. . .

Section 2 Scope and Purpose

The purpose of the amendment to this regulation is to comply with the enactment of Senate Bill 08-057, which mandates coverage of hearing aids for children under the age of 18 and House Bill 08-1410, concerning the coverage of colorectal cancer prevention services. This regulation specifies the requirements for the basic and standard health benefit plans as well as other requirements for small employer carriers.

Section 3 Applicability

This regulation shall apply to all small employer carriers as defined in §10-16-102(41), C.R.S., and to all carriers required to provide conversion products pursuant to §10-16-108, C.R.S.

Section 4 Rules

A. Plans

1. Basic Plan. The form and content of the basic health benefit plan may be one or more of the three plan design options as appended to this regulation and shall constitute the basic health benefit plan design pursuant to §10-16-105(7.2), C.R.S. At least one of these three plan design options, two of which are high deductible, HSA-qualified plan options, shall be required for use in Colorado's small employer group market pursuant to §10-16-105(7.3), C.R.S., and as conversion coverage pursuant to §10-16-108, C.R.S. However, if the carrier chooses to offer more than one basic health benefit plan design, it shall offer all of its basic plan options to every small employer that expresses an interest in the basic health benefit plan or to those individuals purchasing a basic conversion plan.

2. Standard Plan. The form and content of the standard health benefit plan, as appended to this regulation, shall constitute the standard health benefit plan required for use in Colorado's small employer group market pursuant to §10-16-105(7.3), C.R.S., and for use as conversion coverage pursuant to §10-16-108, C.R.S.

BASIC AND STANDARD HEALTH BENEFIT PLAN
POLICY REQUIREMENTS FOR THE STATE OF COLORADO

Colorado Division of Insurance
Effective January 1, 2009

1. The basic health benefit plan as defined by the Commissioner pursuant to §10-16-105(7.2)(b), C.R.S., for an indemnity, preferred provider organization (PPO), and health maintenance organization (HMO) plan shall include the specific benefits and coverages outlined in one of the attached tables labeled "Basic Limited Mandate Health Benefit Plan", "Basic HSA Health Benefit Plan", or "Basic HSA Limited Mandate Health Benefit Plan".

2. The standard health benefit plan for an indemnity, PPO, and HMO plan shall include the specific benefits and coverages outlined in the attached table labeled "Standard Health Benefit Plan".

JANUARY 1, 2009 COLORADO BASIC LIMITED MANDATE HEALTH BENEFIT PLANS:

INDEMNITY, PPO

PART B: SUMMARY OF BENEFITS

(Please note: all coinsurance percentages listed are what the carrier will pay for service.)

	BASIC INDEMNITY PLAN	**BASIC PPO PLAN**	
BASIC LIMITED MANDATE HEALTH BENEFIT PLAN		**IN-NETWORK**	**OUT-OF-NETWORK[2]**
5. OUT-OF-POCKET ANNUAL MAXIMUM[3] **(Includes deductibles and coinsurance. Copays apply for the HMO plan only. The prescription drug deductible and all prescription drug copays are**		**(Excludes flat dollar copays.)**	**(Out-of pocket amounts are separate from in-network out-of-pocket amounts.)**
a) Individual	**$ 12,000**	**$ 8,000**	**$ 16,000**
b) Family	**$ 24,000**	**$ 16,000**	**$ 32,000**

[3] "Out-of-pocket maximum" refers to the maximum amount the insured/member will have to pay for allowable covered expenses under a health plan, which includes the deductible, coinsurance and copays, as specified. The deductible and copays for

prescription drugs, however, are not applied to the out-of-pocket maximum. Under this basic plan, copays for other than prescription drugs are applied to the out-of-pocket maximum on HMO plans only.

JANUARY 1, 2009 COLORADO BASIC HSA LIMITED MANDATE HEALTH BENEFIT PLANS:

INDEMNITY, PPO

PART B: SUMMARY OF BENEFITS

(Please note: all coinsurance percentages listed are what the carrier will pay for the service.)

	BASIC INDEMNITY PLAN	**BASIC PPO PLAN**	
Basic HSA Limited Mandate Health Benefit Plan		**IN-NETWORK**	**OUT-OF-NETWORK[1a]**
5. OUT-OF-POCKET ANNUAL MAXIMUM[3] **(Includes deductibles, coinsurance and copays.)**			
a) Single Coverage	**$ 5,500**	**$ 5,500**	**$ 11,000**
b) Non-Single Coverage **(Employee + Spouse or Employee + Children or Employee, Spouse and Children)**	**$ 11,000**	**$ 11,000**	**$ 22,000** **(Out-of pocket amounts are separate from in-network out-of-pocket amounts.)**

[3] "Out-of-pocket maximum" refers to the maximum amount the insured/member will have to pay for allowable covered expenses under a health plan, which includes the deductible, copays, and coinsurance.

JANUARY 1, 2009 COLORADO STANDARD HEALTH BENEFIT PLANS:

INDEMNITY, PPO

PART B: SUMMARY OF BENEFITS

(Please note: all coinsurance percentages listed are what the carrier will pay for service).

		STANDARD PPO PLAN	
	STANDARD INDEMNITY PLAN	**IN-NETWORK**	**OUT-OF-NETWORK[2]**
5. OUT-OF-POCKET ANNUAL MAXIMUM[3] *(Includes deductibles and coinsurance. Copays apply for the HMO plan only. All copays for prescription drugs are excluded.)*		*(Excludes flat dollar copays.)*	*(Out-of-pocket amounts are separate from in-network out-of-pocket amounts.)*
a) Individual	**$ 4,000**	**$ 3,500**	**$ 7,000**
b) Family	**$ 12,000**	**$ 7,000**	**$ 14,000**

[3] "Out-of-pocket maximum" refers to the maximum amount the insured/member will have to pay for allowable covered expenses under a health plan, which includes the deductible, coinsurance and copayments, as specified. Copays for prescription drugs, however, are not applied to the deductible or out-of-pocket maximum. Under the standard plans, copays for other than prescription drugs are applied to the out-of-pocket maximum on HMO plans only.

John Alden's policy forms, in some instances, were not in compliance with Colorado insurance law in that its Individual Health Benefit Conversion Policy [Basic Limited Mandate Health Benefit Plan]; Basic HSA Limited Mandate Health Benefit Plan; and Standard Health Benefit Plan failed to provide accurate Out-of-Pocket Annual Maximums as required by Emergency Insurance Regulation 08-E-12 and Colorado Insurance Regulation 4-6-5.

For example, John Alden's Basic HSA Limited Mandate Health Benefit Plan provided an in-network individual maximum of $5,100 and $10,200 for a family in contrast to the correct requirement of a $5,500 maximum for an individual and $11,000 for a family. The corresponding indemnity and out-of network maximums for this and the Basic and Standard plans have similar deficiencies.

The language in John Alden's Basic Limited Mandate Health Benefit Plan (Individual Health Benefit Conversion Policy) form stated in part:

MAJOR MEDICAL BENEFITS

Family Deductible Limit

Unless otherwise stated in Your Benefit Summary (under "Deductible Amount") or on any attached Rider, when the sum of Deductible Amounts incurred by all family members in a single Year equals the maximum amount per family as shown on Your Benefit Summary or on any attached Rider, further Deductible Amounts will be waived with respect to all Covered Medical Charges incurred by any family members during the rest of that Year.

The language in John Alden's Standard Health Benefit Plan form stated in part:

SCHEDULE OF MEDICAL BENEFITS

Major Medical Benefits for [Single Plan/Family Plan/Employee-Spouse Plan/Employee-Children Plan].

	IN-NETWORK	**OUT-OF-NETWORK**
OUT-OF-POCKET ANNUAL MAXIMUM[2]: [Individual $3,000]	***[Individual $6,000]***	
[Family $6,000]	***[Family $12,000]***	

[Emphasis added.]

[2] Out-Of-Pocket Annual Maximum includes Deductibles and Coinsurance.

The following forms were not in compliance with Colorado insurance law:

Form:		Date:
J-1104-C CO (BAS)	Individual Health Benefit Conversion Policy [Basic Limited Mandate Health Benefits Plan]	3/1995
CO.JA.BasicHD-CC	Basic HSA Limited Mandate Health Benefits Plan	3/2006
CO.JA.Standard-CC	Standard Health Benefits Plan	3/2006

Recommendation No. 17:

John Alden shall be provided a reasonable period, not exceeding thirty (30) days from the date of this report, to make written submission or rebuttal as to why it should not be considered in violation of Colorado Emergency Insurance Regulation 08-E-12 and Amended Regulation 4-6-5. In the event John Alden is unable to show such documentation, the Company may include, with its submission or rebuttal, its plan to comply, or documentation showing it is now in compliance.

Otherwise, John Alden shall be required, within sixty (60) days from the date this report is adopted, to provide written evidence to the Division that it has revised all applicable forms to reflect the correct out-of-pocket maximums as required by Colorado insurance law. Within these sixty (60) days, John Alden

shall also provide the Division with specimen copies of all revised policy forms containing compliant provisions for out-of-pocket maximums and the proposed date that the forms will be put in use.

Issue E18: Failure of the Company's forms, in some instances, to provide accurate information related to annual deductibles.

Colorado Emergency Insurance Regulation 08-E-12 and Amended Regulation 4-6-5, Concerning Small Employer Group Basic and Standard Health Benefit Plans and The Basic and Standard Health Benefit Plans Policy Requirements for the State of Colorado, promulgated under the authority of §§ 10-1-109, 10-16-105(7.2), 10-16-108.5(8), and 10-16-109, C.R.S., state in part:*

*Emergency Regulation 08-E-12 (effective January 1, 2009) was replaced in its entirety by Amended Regulation 4-6-5, which was effective February 1, 2009. Other than the effective dates, the required benefits are identical for both regulations.

. . .

Section 2 Scope and Purpose

The purpose of the amendment to this regulation is to comply with the enactment of Senate Bill 08-057, which mandates coverage of hearing aids for children under the age of 18 and House Bill 08-1410, concerning the coverage of colorectal cancer prevention services. This regulation specifies the requirements for the basic and standard health benefit plans as well as other requirements for small employer carriers.

Section 3 Applicability

This regulation shall apply to all small employer carriers as defined in §10-16-102(41), C.R.S., and to all carriers required to provide conversion products pursuant to §10-16-108, C.R.S.

Section 4 Rules

A. Plans

1. Basic Plan. The form and content of the basic health benefit plan may be one or more of the three plan design options as appended to this regulation and shall constitute the basic health benefit plan design pursuant to §10-16-105(7.2), C.R.S. At least one of these three plan design options, two of which are high deductible, HSA-qualified plan options, shall be required for use in Colorado's small employer group market pursuant to §10-16-105(7.3), C.R.S., and as conversion coverage pursuant to §10-16-108, C.R.S. However, if the carrier chooses to offer more than one basic health benefit plan design, it shall offer all of its basic plan options to every small employer that expresses an interest in the basic health benefit plan or to those individuals purchasing a basic conversion plan.

2. Standard Plan. The form and content of the standard health benefit plan, as appended to this regulation, shall constitute the standard health benefit plan required for use in Colorado's small employer group market pursuant to §10-16-105(7.3), C.R.S., and for use as conversion coverage pursuant to §10-16-108, C.R.S.

BASIC AND STANDARD HEALTH BENEFIT PLAN
POLICY REQUIREMENTS FOR THE STATE OF COLORADO

Colorado Division of Insurance
Effective January 1, 2009

1. The basic health benefit plan as defined by the Commissioner pursuant to §10-16-105(7.2)(b), C.R.S., for an indemnity, preferred provider organization (PPO), and health maintenance organization (HMO) plan shall include the specific benefits and coverages outlined in one of the attached tables labeled "Basic Limited Mandate Health Benefit Plan", "Basic HSA Health Benefit Plan", or "Basic HSA Limited Mandate Health Benefit Plan".

2. The standard health benefit plan for an indemnity, PPO, and HMO plan shall include the specific benefits and coverages outlined in the attached table labeled "Standard Health Benefit Plan".

JANUARY 1, 2009 COLORADO BASIC LIMITED MANDATE HEALTH BENEFIT PLANS:

INDEMNITY, PPO

PART B: SUMMARY OF BENEFITS

(Please note: all coinsurance percentages listed are what the carrier will pay for service.)

	BASIC INDEMNITY PLAN	**BASIC PPO PLAN**	
BASIC LIMITED MANDATE HEALTH BENEFIT PLAN		**IN-NETWORK**	**OUT-OF-NETWORK[2]**
4. ANNUAL DEDUCTIBLE *(Deductibles do not apply to benefits with flat dollar copays*		(Deductibles are separate from in-network	
a) Individual	**$ 4,000**	**$ 4,000**	**$ 8,000**
b) Family	**$ 12,000**	**$ 12,000**	**$ 24,000**

[2] Out-of-network cost sharing (deductibles, coinsurance, and out-of-pocket maximums) levels apply ***ONLY IF*** plan has network providers for the covered benefit and insured/member goes out of the network. Otherwise, in-network levels apply.

JANUARY 1, 2009 COLORADO BASIC HSA LIMITED MANDATE HEALTH BENEFIT PLANS:

INDEMNITY, PPO

PART B: SUMMARY OF BENEFITS

(Please note: all coinsurance percentages listed are what the carrier will pay for the service.)

	BASIC INDEMNITY PLAN	**BASIC PPO PLAN**	
Basic HSA Limited Mandate Health Benefit Plan		**IN-NETWORK**	**OUT-OF-NETWORK[1a]**
4. ANNUAL DEDUCTIBLE [2]	***For all plans, deductible applies to all services unless specifically noted.***		
a) Single Coverage	**$ 4,000**	**$ 4,000**	**$ 8,000**
b) Non-Single Coverage (Employee + Spouse *or* Employee + Children *or* Employee, Spouse and Children)	**$ 8,000**	**$ 8,000**	**$ 16,000** *(Deductibles are separate from in-network deductibles)*

[1a] Out-of-network cost sharing (deductibles, coinsurance, and out-of-pocket maximums) levels apply ***ONLY IF*** plan has network providers for the covered benefit and insured/member goes out of the network. Otherwise, in-network-levels apply.

[2] "Annual Deductible". The stated annual deductible **MUST** be met prior to any benefits being payable except as otherwise indicated.

JANUARY 1, 2009 COLORADO STANDARD HEALTH BENEFIT PLANS:

INDEMNITY, PPO

PART B: SUMMARY OF BENEFITS

(Please note: all coinsurance percentages listed are what the carrier will pay for service).

		STANDARD PPO PLAN	
	STANDARD INDEMNITY PLAN	**IN-NETWORK**	**OUT-OF-NETWORK** [2]
4. ANNUAL DEDUCTIBLE *(Deductibles do not apply to benefits with flat dollar copays except as noted.)*		(Deductibles are separate from in-network deductibles)	
a) Individual	**$ 2,000**	**$ 1,500**	**$ 3,000**
b) Family	**$ 6,000**	**$ 4,500**	**$ 9,000**

[2] Out-of-network cost sharing (deductibles, coinsurance, and out-of-pocket maximums) levels apply ***ONLY IF*** plan has network providers for the covered benefit and insured/member goes out of the network. Otherwise, in-network-levels apply.

John Alden, in some instances, was not in compliance with Colorado insurance law in that its Individual Health Benefit Conversion Policy [Basic Limited Mandate Health Benefit Plan]; Basic HSA Limited Mandate Health Benefit Plan; and Standard Health Benefit Plan forms failed to provide accurate Annual Deductibles as required by Colorado Insurance Regulation 4-6-5.

For example, the Basic HSA Limited Mandate Health Benefit Plan provided an in-network deductible of $3,000 for an individual and $6,000 for a family in contrast to the correct requirement of a $4,000 deductible for an individual and $8,000 for a family. The corresponding indemnity and out-of network deductibles for this and the Basic and Standard plans had similar deficiencies.

The language in John Alden's Basic Limited Mandate Health Benefit Plan (Individual Health Benefit Conversion Policy) form stated in part:

MAJOR MEDICAL BENEFITS

Deductible Amount

The Deductible Amount for each Insured Person as described in the Benefit Summary or any attached rider. You and/or Your Insured Dependents must, while insured, incur Covered Medical Charges of at least this amount within a Year before any Major Medical Benefit are payable during that year. An exception to this would be anything otherwise stated Your Benefit Summary or on any attached Riders. Covered Medical Charges incurred during the last 3 months of the Year that are applied to the Deductible Amount for that Year will also be applied toward the Deductible amount for the next year.

Family Deductible Limit

Unless otherwise stated in Your Benefit Summary (under "Deductible Amount") or on any attached Rider, when the sum of Deductible Amounts incurred by all family members in a single Year equals the maximum amount per family as shown on Your Benefit Summary or on any attached Rider, further Deductible Amounts will be

waived with respect to all Covered Medical Charges incurred by any family members during the rest of that Year.

The language in John Alden's Basic HSA Limited Mandate Preferred Provider Benefit Summary stated in part:

SCHEDULE OF MEDICAL BENEFITS

Major Medical Benefits for [Single Plan/Family Plan/Employee-Spouse Plan/Employee-Child Plan].

	IN-NETWORK	**OUT-OFNETWORK**
ANNUAL DEDUCTIBLE[1]:	***[Individual $3,000]***	***[Individual $6,000]***
	[Family $6,000]	***[Family $12,000]***

[Emphases added.]

[2] "Annual Deductible". The stated annual deductible **MUST** be met prior to any benefits being payable except as otherwise indicated.

The language in John Alden's Standard Health Benefit Plan form stated in part:

SCHEDULE OF MEDICAL BENEFITS

Major Medical Benefits for [Single Plan/Family Plan/Employee-Spouse Plan/Employee-Children Plan].

ANNUAL DEDUCTIBLE[1]:	***[Individual $3,000]***
	[Family $12,000]

[Emphasis added.]

The following forms were not in compliance:

Form:		Date:
J-1104-C CO (BAS)	Individual Health Benefit Conversion Policy [Basic Limited Mandate Health Benefits Plan]	3/1995
CO.JA.BasicHD-CC	Basic HSA Limited Mandate Health Benefits Plan	3/2006
CO.JA.Standard-CC	Standard Health Benefits Plan	3/2006

Recommendation No. 18:

John Alden shall be provided a reasonable period, not exceeding thirty (30) days for the date of this report, to make written submission or rebuttal as to why it should not be considered in violation of Colorado Emergency Insurance Regulation 08-E-12 and Amended Regulation 4-6-5. In the event John Alden is unable to show such proof, the Company may include, with its submission or rebuttal, its plan to comply, or documentation showing it is now in compliance.

Otherwise, John Alden shall be required, within sixty (60) days from the date this report is adopted, to provide written evidence to the Division that it has revised all applicable forms to reflect correct annual deductible amounts as required by Colorado insurance law. Within these sixty (60) days, John Alden shall also provide the Division with specimen copies of all revised policy forms containing compliant provisions for annual deductible amounts and the proposed date that the forms will be put in use.

Issue E19: Failure of the Company's Basic and Standard Health Benefit Plan forms to outline the benefits provided in the required form with the required content.

Colorado Emergency Insurance Regulation 08-E-12 and Amended Regulation 4-6-5, Concerning Small Employer Group Basic and Standard Health Benefit Plans and The Basic and Standard Health Benefit Plans Policy Requirements for the State of Colorado, promulgated under the authority of §§ 10-1-109, 10-16-105(7.2), 10-16-108.5(8), and 10-16-109, C.R.S., state in part:*

*Emergency Regulation 08-E-12 (effective January 1, 2009) was replaced in its entirety by Amended Regulation 4-6-5, which was effective February 1, 2009. Other than the effective dates, the required benefits are identical for both regulations.

. . .

Section 2 Scope and Purpose

The purpose of this emergency regulation is to comply with the enactment of Senate Bill 08-057, which mandates coverage of hearing aids for children under the age of 18 and House Bill 08-1410, concerning the coverage of colorectal cancer prevention services. *This emergency regulation specifies the requirements for the basic and standard health benefit plans as well as other requirements for small employer carriers.* [Emphasis added.]

Section 3 Applicability

This regulation shall apply to all small employer carriers as defined in §10-16-102(41), C.R.S., and to all carriers required to provide conversion products pursuant to §10-16-108, C.R.S.

Section 4 Rules

A. Plans

1. Basic Plan. The form and content of the basic health benefit plan may be one or more of the three plan design options as appended to this regulation and shall constitute the basic health benefit plan design pursuant to §10-16-105(7.2), C.R.S. At least one of these three plan design options, two of which are high deductible, HSA-qualified plan options, shall be required for use in Colorado's small employer group market pursuant to §10-16-105(7.3), C.R.S., and as conversion coverage pursuant to §10-16-108, C.R.S. However, if the carrier chooses to offer more than one basic health benefit plan design, it shall offer all of its basic plan options to every small employer that expresses an interest in the basic health benefit plan or to those individuals purchasing a basic conversion plan.

2. Standard Plan. The form and content of the standard health benefit plan, as appended to this regulation, shall constitute the standard health benefit plan required for use in Colorado's small employer group market pursuant to §10-16-105(7.3), C.R.S., and for use as conversion coverage pursuant to §10-16-108, C.R.S.

B. The basic and standard health benefit plans shall be identified as specified below.

1. *Each small employer carrier shall title and market its basic health benefit plan as follows: "[Carrier name] [Type of plan (i.e., Indemnity, Preferred Provider or HMO) (Basic Limited Mandate Health Benefit Plan, Basic HSA Health Benefit Plan or Basic HSA Limited Mandate Health Benefit Plan)] for Colorado".*

2. *Each small employer carrier shall title and market the standard health benefit plan as follows: "[Carrier name] [Type of plan (i.e., Indemnity, Preferred Provider, or HMO)] Standard Health Benefit Plan for Colorado".* [Emphasis added.]

John Alden was not in compliance with Colorado insurance law in that its policy forms (CO.JA.BasicHD-CC and CO.JAStandard) for the Basic and Standard Health Benefit Plan forms did not outline the benefits of each respective plan in the required form and include the required content. The Company's forms were set-up as blended policies that included both indemnity benefits and explanations as well as preferred provider organization (PPO) descriptions, and were noted to be misleading and confusing to insureds. It was difficult to determine at what levels coinsurance, deductibles and other benefits were to be paid as John Alden refers in the body of the policy to both indemnity and PPO benefits.

The following example demonstrated the possible misinterpretation or confusion that may have resulted when reviewing the policy for benefits:

Front page of Policies by type:

POLICY OF GROUP INSURANCE

***[Indemnity] [Preferred Provider] Standard* Health Benefit Plan for Colorado**

POLICY OF GROUP INSURANCE

***[Indemnity] [Preferred Provider] Basic HSA Limited Mandate* Health Benefit Plan for Colorado**

The following described benefits in the plan that referred to both and Basic and Standard indemnity and PPO health plans:

We will cover charges:

1. For routine medical office visits when performed by or at the direction of a Physician, and including outpatient X-rays and laboratory services, up to the benefit limit shown in Your Benefit Summary.

for regular PPO plan

Benefits for routine medical office visits to an In-Network primary care physician are subject to a [[$25] Copayment], and a [[$40] Copayment] for routine medical office visits to an In-Network specialist. Benefits for routine medical office visits to an

Out-of-Network primary care physician and/or specialist are payable at [50%] after satisfaction of the Annual Deductible.

for regular PPO plan

If lab and x-ray services are delivered as part of an office visit to a covered person's designated In-Network primary care provider, then there is no additional Copayment or Coinsurance requirement for these services.

I. PREVENTIVE CARE

We will cover charges for the following:

for regular PPO alone

Each In-Network Physician visit for Covered Wellness Services is subject to a [[$25] Copayment]. This Copayment amount will count towards the Out-of-Pocket limit.

for indemnity plan alone

Covered Children's Wellness Services are not subject to satisfaction of the Annual Deductible requirement.

II. MATERNITY BENEFITS

We will cover charges:

for regular PPO plan

After this Copayment has been satisfied, all other benefits are payable at [80%] after satisfaction of the Annual Deductible.

VIII. EMERGENCY SERVICES:

for regular PPO only

Benefits for Emergency Room Visits are subject to a [[$125] Copayment]. After satisfaction of the [Copayment] amount and any Annual Deductible, we will pay benefits at [80%].

[(When Deductible and Coinsurance is Waived)]

Application of Deductible and Coinsurance to [Network/Non-Network] Services

A Copayment is a fee that You must pay directly to the Provider at the time service is rendered. [When You incur Covered Medical Charges from a Provider and those charges are subject to a Copayment, the [Network] Deductible and [Network] Coinsurance Percentage will be waived.] The Copayment is shown on Your Benefit Summary.

[(When Deductible or Coinsurance or both should still apply)]

Application of Copayment to [Network/Non Network] Services

A Copayment is a fee that You must pay directly to the Provider at the time service is rendered. [When You incur Covered Medical Charges from a Provider and those charges are subject to a Copayment, the [Network] [Deductible] [Network]

[Coinsurance Percentage] will still apply.] The Copayment is shown on Your Benefit Summary.

[When Copayments include a "maximum"]
Application of Copayment to [Network/Non-Network] Services
When you incur Covered Medical Charges from a Provider and those charges are subject to a Copayment with a maximum dollar amount of Covered Medical Charges, [the [Network/Non-Network] Deductible [and] Coinsurance] will be waived until an Insured Person has incurred Covered Medical Charges equal to the maximum stated in Your Benefit summary for those charges. Additional Covered Medical Charges incurred in the same Year for that Insured Person in excess of this maximum for charges subject to a Copayment will be subject to [Network/Non-Network] Deductible and Coinsurance for the remainder of that Year and the Copayment will be waived.

Out-of-Pocket Limit
[*For use with plans where all non-network services are subject to Non-Network requirements]*
Your Benefit Summary reflects You have both a Network Out-of-Pocket Limit and a Non-Network Out-of-Pocket Limit. Any amount You satisfy toward Your Non-Network Out-of-Pocket Limit will also be applied toward satisfaction of Your Network Out-of-Pocket Limit. **The Non-Network Out-of-Pocket Limit cannot be satisfied by Network Out-of-Pocket Limits.**

[**If plan is a Preferred Hospital Network or Preferred Provider Plan**]
Covered Medical Charges as stated in the Medical Benefits section of Your Policy will be paid at the Network Benefit Percentage shown in Your Benefit Summary when such charges are incurred from a Network Provider. IT IS YOUR RESPONSIBILITY TO DETERMINE IF THE PROVIDER RENDERING THE SERVICES IS A NETWORK PROVIDER WHEN SUCH SERVICES ARE RENDERED.

NON-NETWORK BENEFITS
Non-Network Benefits are paid at the Non-Network Benefit Percentage for any Covered Medical Charges that do not meet the requirements for Network Benefits, as shown in the "Schedule of Medical Benefits". *[In some instances, no benefits may be available for some services if rendered by a Non-Network Provider, and You are responsible for payment of all the charges.]* [Emphasis added.]

[If plan is a Scheduled Network Plan]
Covered Medical Charges will be based on a network schedule of Negotiated Fees for charges incurred while insured. [Emphasis added.]

NON-NETWORK BENEFITS

a) The Insured seeks care from a Participating Provider for any continued care as soon as medically able.

If, because of the patient's condition, it is not possible to give such notice within this time limit, notification must be made as soon as possible.

2. However, in the event Covered Medical Charges are incurred for any service, treatment or supply for which no Negotiated Fee has been determined, Covered Medical Charges will be based on the Usual, Customary and Reasonable amount.

YOU ARE FREE TO USE ANY PROVIDER YOU WANT. IT IS YOUR RESPONSIBILITY TO DETERMINE IF A PROVIDER IS A NETWORK PROVIDER OR A NON-NETWORK PROVIDER BEFORE ANY SERVICES ARE RENDERED. [Emphasis in original.]

[If Plan is a Gatekeeper [Plus] Plan] [Emphasis added.]
The following requirements must be met in order to receive Network Benefits, as shown in the "Schedule of Medical Benefits":

John Alden had blended policies to include benefit descriptions for both Basic and Standard Indemnity and PPO health benefit plans, which may have prevented a policyholder from understanding the differences between the plans.

Form:		Date:
J-1104-C CO (BAS)	Individual Health Benefit Conversion Policy [Basic Limited Mandate Health Benefits Plan]	3/1995
CO.JA.BasicHD-CC	Basic HSA Limited Mandate Health Benefits Plan	3/2006
CO.JA.Standard-CC	Standard Health Benefits Plan	3/2006

Recommendation No. 19:

John Alden shall be provided a reasonable period, not exceeding thirty (30) days from the date of this report, to make written submission or rebuttal as to why it should not be considered in violation of Colorado Emergency Insurance Regulation 08-E-12 and Amended Regulation 4-6-5. In the event John Alden is unable to show such documentation, the Company may include, with its submission or rebuttal, its plan to comply or documentation showing it is now in compliance.

Otherwise, John Alden shall be required, within sixty (60) days from the date this report is adopted, to provide written evidence to the Division that it has revised all applicable forms to reflect the correct benefit plans as required by Colorado insurance law. Within these sixty (60) days, John Alden shall also provide the Division with specimen copies of all revised policy forms containing compliant benefit plan descriptions to small employers and the proposed date that the forms will be put in use.

Issue E20: Failure of the Company's forms, in some instances, to reflect complete or accurate information related to prescription coverage.

Colorado Emergency Insurance Regulation 08-E-12 and Amended Regulation 4-6-5, Concerning Small Employer Group Basic and Standard Health Benefit Plans and The Basic and Standard Health Benefit Plans Policy Requirements for the State of Colorado, promulgated under the authority of §§ 10-1-109, 10-16-105(7.2), 10-16-108.5(8), and 10-16-109, C.R.S., state in part:*

*Emergency Regulation 08-E-12 (effective January 1, 2009) was replaced in its entirety by Amended Regulation 4-6-5, which was effective February 1, 2009. Other than the effective dates, the required benefits are identical for both regulations.

. . .

Section 2 Scope and Purpose

The purpose of the amendment to this regulation is to comply with the enactment of Senate Bill 08-057, which mandates coverage of hearing aids for children under the age of 18 and House Bill 08-1410, concerning the coverage of colorectal cancer prevention services. This regulation specifies the requirements for the basic and standard health benefit plans as well as other requirements for small employer carriers.

Section 3 Applicability

This regulation shall apply to all small employer carriers as defined in §10-16-102(41), C.R.S., and to all carriers required to provide conversion products pursuant to §10-16-108, C.R.S.

Section 4 Rules

A. Plans

1. Basic Plan. The form and content of the basic health benefit plan may be one or more of the three plan design options as appended to this regulation and shall constitute the basic health benefit plan design pursuant to §10-16-105(7.2), C.R.S. At least one of these three plan design options, two of which are high deductible, HSA-qualified plan options, shall be required for use in Colorado's small employer group market pursuant to §10-16-105(7.3), C.R.S., and as conversion coverage pursuant to §10-16-108, C.R.S. However, if the carrier chooses to offer more than one basic health benefit plan design, it shall offer all of its basic plan options to every small employer that expresses an interest in the basic health benefit plan or to those individuals purchasing a basic conversion plan.

2. Standard Plan. The form and content of the standard health benefit plan, as appended to this regulation, shall constitute the standard health benefit plan required for use in Colorado's small employer group market pursuant to §10-16-105(7.3), C.R.S., and for use as conversion coverage pursuant to §10-16-108, C.R.S.

BASIC AND STANDARD HEALTH BENEFIT PLAN
POLICY REQUIREMENTS FOR THE STATE OF COLORADO

Colorado Division of Insurance
Effective January 1, 2009

1. The basic health benefit plan as defined by the Commissioner pursuant to §10-16-105(7.2)(b), C.R.S., for an indemnity, preferred provider organization (PPO), and health maintenance organization (HMO) plan shall include the specific benefits and coverages outlined in one of the attached tables labeled "Basic Limited Mandate Health Benefit Plan", "Basic HSA Health Benefit Plan", or "Basic HSA Limited Mandate Health Benefit Plan".

2. The standard health benefit plan for an indemnity, PPO, and HMO plan shall include the specific benefits and coverages outlined in the attached table labeled "Standard Health Benefit Plan".

JANUARY 1, 2009 COLORADO BASIC LIMITED MANDATE HEALTH BENEFIT PLANS:

INDEMNITY, PPO

PART B: SUMMARY OF BENEFITS

(Please note: all coinsurance percentages listed are what the carrier will pay for service.)

	BASIC INDEMNITY PLAN	**BASIC PPO PLAN**	
BASIC LIMITED MANDATE HEALTH BENEFIT PLAN		**IN-NETWORK**	**OUT-OF-NETWORK[2]**
11. PRESCRIPTION DRUGS [9] **Deductible** *(Must be satisfied prior to application of copays.)*	$100 annual deductible per person	$100 annual deductible per person	
(Deductible and copays do not apply to out-of-pocket maximums.)	$20 copay preferred generic; $50 copay preferred brand name $70 copay non-preferred [9a]	$20 copay preferred generic; $50 copay preferred brand name $70 copay non-preferred [9a]	

[2] Out-of-network cost sharing (deductibles, coinsurance, and out-of-pocket maximums) levels apply ***ONLY IF*** plan has network providers for the covered

benefit and insured/member goes out of the network. Otherwise, in-network levels apply.

[9] Includes expendable medical supplies for the treatment of diabetes. Carriers are allowed to provide a mail order benefit or discount in the manner they do for their most frequently sold non-basic, non-standard group health benefit plan in Colorado. Additionally, as noted above in footnote 3, prescription drug benefits, are not applied to the out-of-pocket maximums. Coverage levels for injectable drugs are based on place of service (e.g., office: included under office visit copay; pharmacy: covered at appropriate copay level based on drug type).

JANUARY 1, 2009 COLORADO BASIC HSA LIMITED MANDATE HEALTH BENEFIT PLANS:

INDEMNITY, PPO

PART B: SUMMARY OF BENEFITS

(Please note: all coinsurance percentages listed are what the carrier will pay for the service.)

	BASIC INDEMNITY PLAN	**BASIC PPO PLAN**	
Basic HSA Limited Mandate Health Benefit Plan		**IN-NETWORK**	**OUT-OF-NETWORK[1a]**
11. PRESCRIPTION DRUGS [7, 8] *(Deductible and out-of-pocket maximums apply.)*	50% coinsurance	50% coinsurance	50% coinsurance

[1a] Out-of-network cost sharing (deductibles, coinsurance, and out-of-pocket maximums) levels apply *ONLY IF* plan has network providers for the covered benefit and insured/member goes out of the network. Otherwise, in-network-levels apply.

[7] Includes expendable medical supplies for the treatment of diabetes. Carriers are allowed to provide a mail order benefit or discount in the manner they do for their most frequently sold non-basic, non-standard group health plan in Colorado.

[8] Prescription drugs otherwise excluded are not covered.

JANUARY 1, 2009 COLORADO STANDARD HEALTH BENEFIT PLANS:

INDEMNITY, PPO

PART B: SUMMARY OF BENEFITS

(Please note: all coinsurance percentages listed are what the carrier will pay for service).

		STANDARD PPO PLAN	
	STANDARD INDEMNITY PLAN	**IN-NETWORK**	**OUT-OF-NETWORK[2]**
11. PRESCRIPTION DRUGS [9] *(Copays do not apply to out-of-pocket maximums.)*	$ 10 copay preferred generic; $ 40 copay preferred brand name $ 60 copay non-preferred [9a]	$ 10 copay preferred generic; $ 40 copay preferred brand name $ 60 copay non-preferred [9a]	$ 10 copay preferred generic; $ 40 copay preferred brand name $ 60 copay non-preferred [9a]

[2] Out-of-network cost sharing (deductibles, coinsurance, and out-of-pocket maximums) levels apply ***ONLY IF*** plan has network providers for the covered benefit and insured/member goes out of the network. Otherwise, in-network-levels apply.

[9] Includes expendable medical supplies for the treatment of diabetes. Carriers are allowed to provide a mail order benefit or discount in the manner they do for their most frequently sold non-basic, non-standard group health plan in Colorado. Additionally, as noted above in footnote 3, prescription drug benefits are not subject to the deductible and the copays are not applied to the out-of-pocket maximums. Coverage levels for injectable drugs are based on place of service (office: included under office visit copay; pharmacy: covered at appropriate copay level based on drug type).

[9a] Prescription drugs otherwise excluded are not covered, regardless of whether preferred generic, preferred brand name, or non-preferred.

John Alden, in some instances, was not in compliance with Colorado insurance law in that its Individual Health Benefit Conversion Policy [Basic Limited Mandate Health Benefit Plan]; Basic HSA Limited Mandate Health Benefit Plan; and Standard Health Benefit Plan forms failed to provide accurate Prescription coverage information as required by Colorado Insurance Regulation 4-6-5.

For example: the Basic Health Benefit Plan failed to provide any information regarding copayment percentages; the Basic HSA Limited Mandate Health Benefit Plan simply stated that the 'Copayment' (for purposes of the Outpatient Prescription Drug benefit only) means the amount, as shown on the Benefit Summary, You pay each time a prescription is filled before benefits are paid. When a Member Pharmacy is used, You pay the Copayment directly to the Member Pharmacy each time a prescription is filled. Your Copayment applies after the Prescription Drug Deductible is satisfied' "; and, the Standard Health Benefit Plan listed incorrect copayment percentages for brand name and non-preferred prescriptions.

The language in John Alden's Basic Limited Mandate Health Benefit Plan (Individual Health Benefit Conversion Policy) form stated in part:

MAJOR MEDICAL BENEFITS

Covered Medical Charges

Covered Medical Charges must be Medically Necessary and incurred by You, or Your Insured Dependent, while insured. A charge is deemed incurred as of the date of the service, treatment or purchase giving rise to the charge. Subject to the *"Charges* Not Covered" and "Limitations" sections that follow, Covered Medical Charges include charges:

. . .

10. for drugs or medicines which can only be purchased with a Physician's prescription (including contraceptives that require a Physician's prescription and insulin) and are dispensed by a licensed pharmacist.

The language in John Alden's Basic HSA Limited Mandate Preferred Provider Benefit Summary stated in part:

SECTION VII: OUTPATIENT PRESCRIPTION DRUG BENEFITS Payment of Benefits

Subject to the Charges Not Covered section which follows, We will pay Outpatient Prescription Drug Benefits for Covered Outpatient Prescription Drug Charges that You or Your insured Dependents incur.

To obtain benefits at a Member pharmacy, present your ID card. Certain drugs require preauthorization prior to dispensing and review for possible coverage. Once you pay the Prescription Drug Deductible and/or Copayment, any coinsurance and/or any Ancillary Charge, we will pay benefits up to a [30 consecutive day] supply for each prescription [or up to a [90 consecutive day] supply for each prescription from the mail order service] unless restricted by the manufacturer's packaging or the prescription order. Some products may be subject to additional supply limits. If two or more drug products are packaged together, You may be required to pay a Copayment for each drug product in the packaging.

. . .

"Copayment" (for purposes of the Outpatient Prescription Drug benefit only) means the amount, as shown on the Benefit Summary, that You pay each time a prescription is filled before benefits are paid. When a Member Pharmacy is used, You pay the Copayment directly to the Member Pharmacy each time a prescription is filled. Your Copayment applies after the Prescription Drug Deductible is satisfied.

The language in John Alden's Standard Health Benefit Plan form stated in part:

SECTION VII: OUTPATIENT PRESCRIPTION DRUG BENEFITS
Payment of Benefits

Subject to the Charges Not Covered section which follows, We will pay Outpatient Prescription Drug Benefits for Covered Outpatient Prescription Drug Charges that You or Your insured Dependents incur.

To obtain benefits at a Member pharmacy, present your ID card. Certain drugs require preauthorization prior to dispensing and review for possible coverage. Once you pay the Prescription Drug Deductible and/or Copayment, any coinsurance and/or any Ancillary Charge, we will pay benefits up to a [30 consecutive day] supply for each prescription [or up to a [90 consecutive day] supply for each prescription from the mail order service] unless restricted by the manufacturer's packaging or the prescription order. Some products may be subject to additional supply limits. If two or more drug products are packaged together, You may be required to pay a Copayment for each drug product in the packaging.

. . .

"Copayment" (for purposes of the Outpatient Prescription Drug benefit only) means the amount, as shown on the Benefit Summary, that You pay each time a prescription is filled before benefits are paid. When a Member Pharmacy is used, You pay the Copayment directly to the Member Pharmacy each time a prescription is filled. Your Copayment applies after the Prescription Drug Deductible is satisfied.

. . .

Payment for a prescription drug does not constitute any assumption of liability for any illness, injury, or condition under the Medical Benefits section of this Policy. When a covered prescription drug is available under two or more names or manufacturers' packaging or when more than one covered drug may be used to treat a condition, We will cover the least expensive drug.

Benefits for covered prescription drugs are subject to the following Copayment amounts:

a. [$10] Copayment for preferred *generic drugs;*
b. [$30] Copayment for preferred *brand name drugs;* and
c. [$50] Copayment for non-preferred prescription drugs

Outpatient Prescription Drug benefits are not subject to the Annual Deductible and the Copayment amounts are not applied to the out-of-pocket maximums.

The following forms were not in compliance with Colorado insurance law:

Form:		Date:
J-1104-C CO (BAS)	Individual Health Benefit Conversion Policy [Basic Limited Mandate Health Benefits Plan]	3/1995
CO.JA.BasicHD-CC	Basic HSA Limited Mandate Health Benefits Plan	3/2006
CO.JA.Standard-CC	Standard Health Benefits Plan	3/2006

Recommendation No. 20:

John Alden shall be provided a reasonable period, not exceeding thirty (30) days from the date of this report, to make written submission or rebuttal as to why should not be considered in violation of Colorado Emergency Insurance Regulation 8-E-12 and Amended Regulation 4-6-5. In the event John Alden is unable to provide such documentation, the Company may include, with its submission or rebuttal, its plan to comply or documentation showing it is now in compliance.

Otherwise, John Alden shall be required, within sixty (60) days from the date this report is adopted, to provide written evidence to the Division that it has revised all applicable forms to reflect complete and accurate prescription coverage information as required by Colorado insurance law. Within these sixty (60) days, John Alden shall also provide the Division with specimen copies of all revised policy forms containing compliant provisions for prescription coverage and the proposed date that the forms will be put in use.

Issue E21: Failure of the Company's forms, in some instances, to reflect accurate information related to preventive care.

Colorado Emergency Insurance Regulation 08-E-12 and Amended Regulation 4-6-5, Concerning Small Employer Group Basic and Standard Health Benefit Plans and The Basic and Standard Health Benefit Plans Policy Requirements for the State of Colorado, promulgated under the authority of §§ 10-1-109, 10-16-105(7.2), 10-16-108.5(8), and 10-16-109, C.R.S., state in part:*

*Emergency Regulation 08-E-12 (effective January 1, 2009) was replaced in its entirety by Amended Regulation 4-6-5, which was effective February 1, 2009. Other than the effective dates, the required benefits are identical for both regulations.

. . .

Section 2 Scope and Purpose

The purpose of the amendment to this regulation is to comply with the enactment of Senate Bill 08-057, which mandates coverage of hearing aids for children under the age of 18 and House Bill 08-1410, concerning the coverage of colorectal cancer prevention services. This regulation specifies the requirements for the basic and standard health benefit plans as well as other requirements for small employer carriers.

Section 3 Applicability

This regulation shall apply to all small employer carriers as defined in §10-16-102(41), C.R.S., and to all carriers required to provide conversion products pursuant to §10-16-108, C.R.S.

Section 4 Rules

A. Plans

1. Basic Plan. The form and content of the basic health benefit plan may be one or more of the three plan design options as appended to this regulation and shall constitute the basic health benefit plan design pursuant to §10-16-105(7.2), C.R.S. At least one of these three plan design options, two of which are high deductible, HSA-qualified plan options, shall be required for use in Colorado's small employer group market pursuant to §10-16-105(7.3), C.R.S., and as conversion coverage pursuant to §10-16-108, C.R.S. However, if the carrier chooses to offer more than one basic health benefit plan design, it shall offer all of its basic plan options to every small employer that expresses an interest in the basic health benefit plan or to those individuals purchasing a basic conversion plan.

2. Standard Plan. The form and content of the standard health benefit plan, as appended to this regulation, shall constitute the standard health benefit plan required for use in Colorado's small employer group market pursuant to §10-16-105(7.3), C.R.S., and for use as conversion coverage pursuant to §10-16-108, C.R.S.

BASIC AND STANDARD HEALTH BENEFIT PLAN
POLICY REQUIREMENTS FOR THE STATE OF COLORADO

Colorado Division of Insurance
Effective January 1, 2009

1. The basic health benefit plan as defined by the Commissioner pursuant to §10-16-105(7.2)(b), C.R.S., for an indemnity, preferred provider organization (PPO), and health maintenance organization (HMO) plan shall include the specific benefits and coverages outlined in one of the attached tables labeled "Basic Limited Mandate Health Benefit Plan", "Basic HSA Health Benefit Plan", or "Basic HSA Limited Mandate Health Benefit Plan".

2. The standard health benefit plan for an indemnity, PPO, and HMO plan shall include the specific benefits and coverages outlined in the attached table labeled "Standard Health Benefit Plan".

JANUARY 1, 2009 COLORADO BASIC LIMITED MANDATE HEALTH BENEFIT PLANS:

INDEMNITY, PPO

PART B: SUMMARY OF BENEFITS

(Please note: all coinsurance percentages listed are what the carrier will pay for service.)

	BASIC INDEMNITY PLAN	**BASIC PPO PLAN**	
BASIC LIMITED MANDATE HEALTH BENEFIT PLAN		**IN-NETWORK**	**OUT-OF-NETWORK[2]**
9. PREVENTIVE CARE [6]	For all plans, only specified preventive services are covered.		
a) Children's services *(No deductible prior to application of coinsurance.)*	50% coinsurance	$40 copay/visit.	50% coinsurance
b) Adults' services [6a]	50% coinsurance	$40 copay/visit.	50% coinsurance

[2] Out-of-network cost sharing (deductibles, coinsurance, and out-of-pocket maximums) levels apply ***ONLY IF*** plan has network providers for the covered benefit and insured/member goes out of the network. Otherwise, in-network levels apply.

[6] See Attachment 1 for list of covered preventive services. Immunizations for children up to age 13 shall be provided in accordance with Colorado Division of Insurance Bulletin 4.24.

[6a] Prostate cancer screening and routine mammograms are not covered.

JANUARY 1, 2009 COLORADO BASIC HSA LIMITED MANDATE HEALTH BENEFIT PLANS:

INDEMNITY, PPO

PART B: SUMMARY OF BENEFITS

(Please note: all coinsurance percentages listed are what the carrier will pay for the service.)

	BASIC INDEMNITY PLAN	**BASIC PPO PLAN**	
Basic HSA Limited Mandate Health Benefit Plan		**IN-NETWORK**	**OUT-OF-NETWORK[1a]**
9. PREVENTIVE CARE [5]	For all plans, only specified preventive services are covered.		
a) Children's services *(No deductible)*	50% coinsurance	$40 copay/visit.	50% coinsurance
b) Adults' services *(No deductible)*	50% coinsurance	$40 copay/visit.	50% coinsurance

[1a] Out-of-network cost sharing (deductibles, coinsurance, and out-of-pocket maximums) levels apply ***ONLY IF*** plan has network providers for the covered benefit and insured/member goes out of the network. Otherwise, in-network-levels apply.

[5] See Attachment 1 for list of covered preventive services. Immunizations for children up to age 13 shall be provided in accordance with Colorado Division of Insurance Bulletin 4.24.

JANUARY 1, 2009 COLORADO STANDARD HEALTH BENEFIT PLANS: INDEMNITY, PPO

PART B: SUMMARY OF BENEFITS

(Please note: all coinsurance percentages listed are what the carrier will pay for service). [Emphasis added.]

		STANDARD PPO PLAN	
	STANDARD INDEMNITY PLAN	**IN-NETWORK**	**OUT-OF-NETWORK[2]**
9. PREVENTIVE CARE [6]	For all plans, only specified preventive services are covered.		
a) Children's services *(No deductible)*	80% coinsurance	$25 copay/visit.	50% coinsurance
b) Adults' services *(No deductible)* **c) *Colorectal screening services*[6a, 6b]**	80% coinsurance	$25 copay/visit.	50% coinsurance

[2] Out-of-network cost sharing (deductibles, coinsurance, and out-of-pocket maximums) levels apply ***ONLY IF*** plan has network providers for the covered benefit and insured/member goes out of the network. Otherwise, in-network-levels apply.

[6] See Attachment 1 for list of covered preventive services. Immunizations for children up to age 13 shall be provided in accordance with Colorado Division of Insurance Bulletin 4.24.

[6a] This benefit is effective for policies delivered, issued, renewed or reinstated on or after July 1, 2009. Coverage shall be provided for asymptomatic, average risk adults who are 50 years of age or older and covered persons who are at high risk for colorectal cancer, including covered persons who have a family medical history of colorectal cancer; a prior occurrence of cancer or precursor neoplastic polyps; a prior occurrence of a chronic digestive disease condition such as inflammatory bowel disease, Crohn's disease, or ulcerative colitis; or other predisposing factors as determined by the provider. Colorectal cancer screenings are covered prior to July 1, 2009; however, the requirements mandated by §10-16-104(18), C.R.S., do not apply until July 1, 2009.

[6b] Benefits provided for the following tests as determined by the provider to detect adenomatous polyps or colorectal cancer: modalities that are currently included in an "A" recommendation or a "B" recommendation of the U.S. Preventive Services Task Force, or any successor organization, sponsored by the Agency for Healthcare Research and Quality, the health services research arm of the federal Department of Health and Human Services.

John Alden was not in compliance with Colorado insurance law in that its Individual Health Benefit Conversion Policy [Basic Limited Mandate Health Benefit Plan]; Basic HSA Limited Mandate Health Benefit Plan; and Standard Health Benefit Plan forms failed to provide accurate Preventive Care Coinsurance Percentages and Copay Amounts per Visit as required by Colorado Insurance Regulation 4-

6-5. John Alden's plans failed to meet the specific requirements in the following ways: The Basic Health Benefit Plan failed to provide any information regarding copayment percentages or copayment amounts per visit. Instead, the contract referred the reader to "the Co-payment shown under 'Preventive Care Services' on Your Benefit Summary." However, no benefit summary was provided as part of the Basic Health Benefit Plan. The Basic HSA Limited Mandate PPO Health Benefit Plan, with the exception of the In-Network benefit, failed to provide any information regarding coinsurance and copayments. The Standard PPO Health Benefit Plan failed to provide any information regarding coinsurance or copayments per visit except for the In-Network benefit that included an incorrect copayment of $25 instead of the correct $40 requirement included in the regulation.

The language in John Alden's Basic Limited Mandate Health Benefit Plan (Individual Health Benefit Conversion Policy) form stated in part:

MAJOR MEDICAL BENEFITS

. . .

Amount subject to the Co-payment shown under "Preventive Care Services" on Your Benefit Summary.

a. For insured Dependent children (including newborns) up to age 13 years:

i. immunizations, as recommended by the American Academy of Pediatrics;
ii. for newborns up to age 13 months, 5 Well-Child Visits (including a well-baby newborn Child pediatric examination) and 1 PKU test;
iii. for ages 13 months up to age 3 years, 2 Well-Child Visits;
iv. for ages 3 years up to age 7 years, 3 Well-Child Visits; and
v. for ages 7 years up to age 13 years, 3 Well-Child Visits; and

b. For all other Insured Persons:

i. one smoking-cessation education program while insured, not to exceed a maximum benefit of $150;
ii. for ages 13 years up to age 19 years, one annual Age-Appropriate Health Maintenance Visit, one DT and one hepatitis B vaccination, if not given previously;
iii. for ages 19 years up to age 40 years, one DT every 10 years, one Age-Appropriate Health Maintenance Visit every 3 years, and one fasting lipid panel;
iv. for ages 40 years up to age 65 years, one DT every 10 years, one fasting lipid panel every 5 years, 2 colorectal visualizations between ages 50 and 70, and an annual Age-Appropriate Health Maintenance Visit;
v. for ages 65 and older, an annual influenza immunization, one pneumococcal vaccine, one DT every 10 years, 2 colorectal visualizations between ages 50 and 70, and an annual Age-Appropriate Health Maintenance Visit; and

c. For Insured females:

i. for ages 19 years up to age 40 years, one pap smear every 3 years (excluding women who have had a hysterectomy);
ii. for ages 35 years up to age 40 years, one screening mammogram;

iii. for ages 40 years up to age 50 years, one pap smear every 3 years (excluding women who have had a hysterectomy), and one screening mammogram every one to two years;
iv. for ages 50 years up to age 65 years, one pap smear every 3 years (excluding women who have had a hysterectomy), and an annual screening mammogram; and
v. for ages 65 years and older, an annual screening mammogram.

The language in John Alden's Basic HSA Limited Mandate Preferred Provider Benefit Summary stated in part:

COVERED MEDICAL CHARGES

AND

CHARGES NOT COVERED

PREVENTIVE CARE

We will cover charges:

Coverage herein includes:

a. Vaccinations and Immunizations: Coverage is for child immunizations according to the "Schedule for Active Immunizations" chart; 1 influenza immunization per year for a *covered person* age 65 and older; chicken pox vaccination for all persons who have not had chicken pox; 1 hepatitis B vaccination for a *covered person* age 13 to 18, if not given previously; 1 diphtheria-tetanus (TD) vaccination every ten years for a *covered person* age 13 and older; and 1 pneumococcal vaccine for a *covered person* at or after age 65. Immunization deficient children are not bound by "recommended ages" on the immunization chart.

b. Well Child Visits: Covered visits are broken down by age according to the following chart:

Age of Covered	Covered Visits
0-12 months	• 1 newborn home visit during the first week of life if the newborn was released from the hospital less than 48 hours after delivery.
13-35 months	2 well child visits
3-6	3 well child visits
7-12	3 well child visits

c. Smoking Cessation Education: Coverage is for 1 program benefit under physician supervision, in which We will pay up to [$150].

d. Cervical Cancer Screening: Coverage is for 1 pap test per year for cervical cancer screening for females age 13 and older.

e. Age Appropriate Health Maintenance Visits: Covered visits are broken down by age of the *covered person* according to the following chart:

Age of	Covered Visits
13-18	1 age appropriate health maintenance visit per year
19-39	1 age appropriate health maintenance visit every 3 years
40-64	1 age appropriate health maintenance visit every 24 months
65	1 age appropriate health maintenance visit per year.

f. Colorectal Cancer Screening: Coverage is for either annual fecal occult blood testing or 2 colorectal visualizations for a *covered person* between the ages of 50 and 75.

g. Fasting Lipid Panel: Coverage is for 1 fasting lipid panel every 5 years for a *covered person* age 40 to 6.

h. Exams: Coverage is for 1 mammography screening and clinical breast exam every 12 months for a *covered person* age 65 to 74.

Well child visit means a visit to a primary care provider that includes the following elements: age appropriate physical exam (but not a complete physical exam unless this is age appropriate), history, anticipatory guidance and education (e.g., examine family functioning and dynamics, injury prevention counseling, discuss dietary issues, review age appropriate behaviors, etc.), and growth and development assessment. For older children, this also includes safety and health education counseling.

Age appropriate health maintenance visit means an exam which includes the following components: age appropriate physical exam (but not a complete physical exam unless this is age appropriate), history, anticipatory guidance and education (e.g., examine family functioning and dynamics, discuss dietary issues, review health promotion activities of the patient, etc.), and exercise and nutrition counseling (including folate counseling for women of child bearing age).

for regular PPO alone

Each In-Network Physician visit for Covered Wellness Services is subject to a [$40] Copayment]. The In-Network and Out-of-Network benefits are not subject to the *Annual Deductible*, but the copayment for In-Network office visits will count towards the Out-of-Pocket limit.

for indemnity plan alone

Covered Wellness Services are not subject to satisfaction of the *Annual Deductible* requirement.

The language in John Alden's Standard Health Benefit Plan form stated in part:

COVERED MEDICAL CHARGES

AND

CHARGES NOT COVEDRED

We will cover charges for the following:

a. **Vaccinations and Immunizations: Coverage is for child immunizations** according to the "Schedule for Active Immunizations" chart; 1 influenza immunization per year for a *covered person* age 65 and older; chicken pox vaccination for all persons who have not had chicken pox; 1 hepatitis B vaccination for a *covered person* age 13 to 18, if not given previously; 1 diphtheria-tetanus (TD) vaccination every ten years for a *covered person* age 13 and older; and 1 pneumococcal vaccine for a *covered person* at or after age 65. Immunization deficient children are not bound by "recommended ages" on the immunization chart.

b. Well Child Visits: Covered visits are broken down by age according to the following chart:

Age of Covered Dependent	Covered Visits
0-12 months	• 1 newborn home visit during the first week of life if the newborn was released from the hospital less than 48 hours after delivery. • well child visits • 1 PKU
13-35 months	2 well child visits
3-6	3 well child visits
7-12	3 well child visits

c. Smoking Cessation Education: Coverage is for 1 program benefit under physician supervision, in which We will pay up to [$150].

c. Cervical Cancer Screening: Coverage is for 1 pap test per year for cervical cancer screening for females age 13 and older.

d. Age Appropriate Health Maintenance Visits: Covered visits are broken down by age of the *covered person* according to the following chart:

Age of Covered	Covered Visits
13-18	1 age appropriate health maintenance visit per year
19-39	1 age appropriate health maintenance visit every 3 years
40-64	1 age appropriate health maintenance visit every 24 months

65 and older	1 age appropriate health maintenance visit per year

f. Colorectal Cancer Screening: Coverage is for either annual fecal occult blood testing or 2 colorectal visualizations for a *covered person* between the ages of 50 and 75.

g. Fasting Lipid Panel: Coverage is for 1 fasting lipid panel every 5 years for a *covered person* age 40 to 6.

h. Exams: Coverage is for 1 mammography screening and clinical breast exam every 12 months for a *covered person* age 65 to 74.

Well child visit means a visit to a primary care provider that includes the following elements: age appropriate physical exam (but not a complete physical exam unless this is age appropriate), history, anticipatory guidance and education (e.g., examine family functioning and dynamics, injury prevention counseling, discuss dietary issues, review age appropriate behaviors, etc.), and growth and development assessment. For older children, this also includes safety and health education counseling.

Age appropriate health maintenance visit means an exam which includes the following components: age appropriate physical exam (but not a complete physical exam unless this is age appropriate), history, anticipatory guidance and education (e.g., examine family functioning and dynamics, discuss dietary issues, review health promotion activities of the patient, etc.), and exercise and nutrition counseling (including folate counseling for women of child bearing age).

for regular PPO alone

Each In-Network Physician visit for Covered Wellness Services is subject to a [$25] Copayment]. This Copayment amount will count towards the Out-of-Pocket limit. Out-of-Network benefits for Covered Adult Wellness Services are payable only after satisfaction of the Annual Deductible.

for indemnity plan alone

Covered Children's Wellness Services are not subject to satisfaction of the Annual Deductible requirement. Covered Adult's Wellness Services benefits are payable only after satisfaction of the Annual Deductible.

The following forms were not in compliance with Colorado insurance law:

Form:		Date:
J-1104-C CO (BAS)	Individual Health Benefit Conversion Policy [Basic Limited Mandate Health Benefits Plan]	3/1995
CO.JA.BasicHD-CC	Basic HSA Limited Mandate Health Benefits Plan	3/2006
CO.JA.Standard-CC	Standard Health Benefits Plan	3/2006

Recommendation No. 21:

John Alden shall be provided a reasonable period, not exceeding thirty (30) days from the date of this report, to make written submission or rebuttal as to why it should not be considered in violation of Colorado Emergency Insurance Regulation 08-E-12 and Amended Regulation 4-6-5. In the event John Alden is unable to show such documentation, the Company may include, with its submission or rebuttal, its plan to comply, or documentation showing it is now in compliance.

Otherwise, John Alden shall be required, within sixty (60) days from the date this report is adopted, to provide written evidence to the Division that it has revised all applicable forms to reflect the mandatory coverage for preventive care as required by Colorado insurance law. Within these sixty (60) days, John Alden shall also provide the Division with specimen copies of all revised policy forms containing compliant provisions for coverage of preventive care and the proposed date that the forms will be put in use.

Issue E22: Failure of the Company's forms, in some instances, to reflect accurate information related to ambulance coinsurance.

Colorado Emergency Insurance Regulation 08-E-12 and Amended Regulation 4-6-5, Concerning Small Employer Group Basic and Standard Health Benefit Plans and The Basic and Standard Health Benefit Plans Policy Requirements for the State of Colorado, promulgated under the authority of §§ 10-1-109, 10-16-105(7.2), 10-16-108.5(8), and 10-16-109, C.R.S., state in part:*

*Emergency Regulation 08-E-12 (effective January 1, 2009) was replaced in its entirety by Amended Regulation 4-6-5, which was effective February 1, 2009. Other than the effective dates, the required benefits are identical for both regulations.

. . .

Section 2 Scope and Purpose

The purpose of the amendment to this regulation is to comply with the enactment of Senate Bill 08-057, which mandates coverage of hearing aids for children under the age of 18 and House Bill 08-1410, concerning the coverage of colorectal cancer prevention services. This regulation specifies the requirements for the basic and standard health benefit plans as well as other requirements for small employer carriers.

Section 3 Applicability

This regulation shall apply to all small employer carriers as defined in §10-16-102(41), C.R.S., and to all carriers required to provide conversion products pursuant to §10-16-108, C.R.S.

Section 4 Rules

A. Plans

1. Basic Plan. The form and content of the basic health benefit plan may be one or more of the three plan design options as appended to this regulation and shall constitute the basic health benefit plan design pursuant to §10-16-105(7.2), C.R.S. At least one of these three plan design options, two of which are high deductible, HSA-qualified plan options, shall be required for use in Colorado's small employer group market pursuant to §10-16-105(7.3), C.R.S., and as conversion coverage pursuant to §10-16-108, C.R.S. However, if the carrier chooses to offer more than one basic health benefit plan design, it shall offer all of its basic plan options to every small employer that expresses an interest in the basic health benefit plan or to those individuals purchasing a basic conversion plan.

2. Standard Plan. The form and content of the standard health benefit plan, as appended to this regulation, shall constitute the standard health benefit plan required for use in Colorado's small employer group market pursuant to §10-16-105(7.3), C.R.S., and for use as conversion coverage pursuant to §10-16-108, C.R.S.

BASIC AND STANDARD HEALTH BENEFIT PLAN
POLICY REQUIREMENTS FOR THE STATE OF COLORADO

Colorado Division of Insurance

JANUARY 1, 2009 COLORADO BASIC LIMITED MANDATE HEALTH BENEFIT PLANS:

INDEMNITY, PPO

PART B: SUMMARY OF BENEFITS

(Please note: all coinsurance percentages listed are what the carrier will pay for service.) [Emphasis added.]

	BASIC INDEMNITY PLAN	**BASIC PPO PLAN**	
BASIC LIMITED MANDATE HEALTH BENEFIT PLAN		**IN-NETWORK**	**OUT-OF-NETWORK[2]**
16. AMBULANCE	50% coinsurance	70% coinsurance *After satisfaction of in-network deductible.*	

[2] Out-of-network cost sharing (deductibles, coinsurance, and out-of-pocket maximums) levels apply ***ONLY IF*** plan has network providers for the covered benefit and insured/member goes out of the network. Otherwise, in-network levels apply.

John Alden, in some instances, was not in compliance with Colorado insurance law in that its Basic Limited Mandate Health Benefit Plan [Individual Health Benefit Conversion Policy] forms failed to provide information regarding the ambulance coinsurance as required by Colorado Insurance Regulation 4-6-5. John Alden's individual conversion plan failed in meeting the requirement because the contract simply stated that local professional ambulance service is a covered charge.

The language in John Alden's Basic Limited Mandate Health Benefit Plan (Individual Health Benefit Conversion Policy) form stated in part:

MAJOR MEDICAL BENEFITS

. . .

Covered Medical Charges

. . .

6. for local professional ambulance service.

The following form was not in compliance with Colorado insurance law:

Form:		Date:
J-1104-C CO (BAS)	Individual Health Benefit Conversion Policy [Basic Limited Mandate Health Benefits Plan]	3/1995

Recommendation No. 22:

John Alden shall be provided a reasonable period, not exceeding thirty (30) days from the date of this report, to make written submission or rebuttal as to why it should not be considered in violation of Colorado Emergency Insurance Regulation 08-E-12 and Amended Regulation 4-6-5. In the event John Alden is unable to show such documentation, the Company may include, with its submission or rebuttal, its plan to comply or documentation showing it is now in compliance.

Otherwise, John Alden shall be required, within sixty (60) days from the date this report is adopted, to provide written evidence to the Division that it has revised all applicable forms to reflect the correct coinsurance amounts for ambulance transportation as required by Colorado insurance law. Within these sixty (60) days, John Alden shall also provide the Division with specimen copies of all revised policy forms containing compliant provisions for ambulance coinsurance amounts and the proposed date that the forms will be put in use.

Issue E23: Failure of the Company's forms, in some instances, to reflect accurate information related to biologically based mental illness benefits.

Section 10-16-104, C.R.S., Mandatory coverage provisions – definitions, states in part:

. . .

(5.5) Biologically based mental illness and mental disorders.

(a) (I) Every group policy, plan certificate, and contract of a carrier subject to the provisions of part 2, 3, or 4 of this article, except those described in section 10-16-102 (21) (b), shall provide coverage for the treatment of biologically based mental illness that is no less extensive than the coverage provided for a physical illness.

(II) Every group policy, plan certificate, and contract of a carrier subject to the provisions of part 2, 3, or 4 of this article, except a small group plan, as defined in section 10-16-102 (42), and a policy or plan as described in section 10-16-102 (21) (b), shall provide coverage for the treatment of mental disorders that is no less extensive than the coverage provided for a physical illness.

(III) Any preauthorization or utilization review mechanism used in the determination to provide the coverage required by this paragraph (a) shall be the same as, or no more restrictive than, that used in the determination to provide coverage for a physical illness; except that a carrier that does not use utilization review mechanisms in determining whether to provide coverage for a physical illness may use utilization review mechanisms for determining whether to provide coverage for drug and alcohol disorders and eating disorders as part of the required coverage for mental disorders. The commissioner shall adopt such rules as are necessary to carry out the provisions of this subsection (5.5). In promulgating such rules, the commissioner shall recognize that the substance of the mechanisms for preauthorization or utilization review may differ between medical specialties and that such mechanisms shall not be more restrictive with respect to a covered person or a mental health provider for a determination under this paragraph (a) than for any other physical illness.

(IV) As used in this subsection (5.5):

(A) "Biologically based mental illness" means schizophrenia, schizoaffective disorder, bipolar affective disorder, major depressive disorder, specific obsessive-compulsive disorder, and panic disorder.

(B) "Mental disorder" means posttraumatic stress disorder, drug and alcohol disorders, dysthymia, cyclothymia, social phobia, agoraphobia with panic disorder, and general anxiety disorder. The term includes anorexia nervosa and bulimia nervosa to the extent those diagnoses are treated on an out-patient, day treatment, and in-patient basis, exclusive of residential treatment.

(b) Benefits provided under this subsection (5.5) through a small group plan are not required to be provided to the extent that such benefits duplicate benefits required to be provided under subsection (5) of this section.

Colorado Emergency Insurance Regulation 08-E-12 and Amended Regulation 4-6-5, Concerning Small Employer Group Basic and Standard Health Benefit Plans and The Basic and Standard Health Benefit Plans Policy Requirements for the State of Colorado, promulgated under the authority of §§ 10-1-109, 10-16-105(7.2), 10-16-108.5(8), and 10-16-109, C.R.S., state in part:*

*Emergency Regulation 08-E-12 (effective January 1, 2009) was replaced in its entirety by Amended Regulation 4-6-5, which was effective February 1, 2009. Other than the effective dates, the required benefits are identical for both regulations.

. . .

Section 2 Scope and Purpose

The purpose of the amendment to this regulation is to comply with the enactment of Senate Bill 08-057, which mandates coverage of hearing aids for children under the age of 18 and House Bill 08-1410, concerning the coverage of colorectal cancer prevention services. This regulation specifies the requirements for the basic and standard health benefit plans as well as other requirements for small employer carriers.

Section 3 Applicability

This regulation shall apply to all small employer carriers as defined in §10-16-102(41), C.R.S., and to all carriers required to provide conversion products pursuant to §10-16-108, C.R.S.

Section 4 Rules

A. Plans

1. Basic Plan. The form and content of the basic health benefit plan may be one or more of the three plan design options as appended to this regulation and shall constitute the basic health benefit plan design pursuant to §10-16-105(7.2), C.R.S. At least one of these three plan design options, two of which are high deductible, HSA-qualified plan options, shall be required for use in Colorado's small employer group market pursuant to §10-16-105(7.3), C.R.S., and as conversion coverage pursuant to §10-16-108, C.R.S. However, if the carrier chooses to offer more than one basic health benefit plan design, it shall offer all of its basic plan options to every small employer that expresses an interest in the basic health benefit plan or to those individuals purchasing a basic conversion plan.

2. Standard Plan. The form and content of the standard health benefit plan, as appended to this regulation, shall constitute the standard health benefit plan required for use in Colorado's small employer group market

pursuant to §10-16-105(7.3), C.R.S., and for use as conversion coverage pursuant to §10-16-108, C.R.S.

BASIC AND STANDARD HEALTH BENEFIT PLAN
POLICY REQUIREMENTS FOR THE STATE OF COLORADO

Colorado Division of Insurance
Effective January 1, 2009

1. The basic health benefit plan as defined by the Commissioner pursuant to §10-16-105(7.2)(b), C.R.S., for an indemnity, preferred provider organization (PPO), and health maintenance organization (HMO) plan shall include the specific benefits and coverages outlined in one of the attached tables labeled "Basic Limited Mandate Health Benefit Plan", "Basic HSA Health Benefit Plan", or "Basic HSA Limited Mandate Health Benefit Plan".

2. The standard health benefit plan for an indemnity, PPO, and HMO plan shall include the specific benefits and coverages outlined in the attached table labeled "Standard Health Benefit Plan".

JANUARY 1, 2009 COLORADO BASIC LIMITED MANDATE HEALTH BENEFIT PLANS:

INDEMNITY, PPO

PART B: SUMMARY OF BENEFITS

(Please note: all coinsurance percentages listed are what the carrier will pay for service.)

	BASIC INDEMNITY PLAN	**BASIC PPO PLAN**	
BASIC LIMITED MANDATE HEALTH		**IN-NETWORK**	**OUT-OF-NETWORK[2]**
18. BIOLOGICALLY BASED MENTAL ILLNESS [15] CARE	For all plans, coverage is no less extensive than the coverage for any other physical illness under that plan.		

[2] Out-of-network cost sharing (deductibles, coinsurance, and out-of-pocket maximums) levels apply ***ONLY IF*** plan has network providers for the covered benefit and insured/member goes out of the network. Otherwise, in-network levels apply.

[15] "Biologically based mental illnesses" means schizophrenia, schizoaffective disorder, bipolar affective disorder, major depressive disorder, specific obsessive-compulsive disorder, and panic disorder. Outpatient psychotherapy visits for biologically based mental illnesses are covered at the same level as medical office visits; however, the copay amount paid by the insured/member shall not exceed 50% of the charge for any single office visit.

JANUARY 1, 2009 COLORADO BASIC HSA LIMITED MANDATE HEALTH BENEFIT PLANS:

INDEMNITY, PPO

PART B: SUMMARY OF BENEFITS

(Please note: all coinsurance percentages listed are what the *carrier* will pay for the service.)
[Emphasis added.]

	BASIC INDEMNITY PLAN	**BASIC PPO PLAN**	
Basic HSA Limited Mandate Health Benefit Plan		**IN-NETWORK**	**OUT-OF-NETWORK[1a]**
18. BIOLOGICALLY BASED MENTAL ILLNESS [13] CARE	For all plans, coverage is no less extensive than the coverage for any other physical illness under that plan.		

[1a] Out-of-network cost sharing (deductibles, coinsurance, and out-of-pocket maximums) levels apply *ONLY IF* plan has network providers for the covered benefit and insured/member goes out of the network. Otherwise, in-network-levels apply.

[13] "Biologically based mental illnesses" means schizophrenia, schizoaffective disorder, bipolar affective disorder, major depressive disorder, specific obsessive-compulsive disorder, and panic disorder. Outpatient psychotherapy visits for biologically based mental illnesses are covered at the same level as medical office visits.

JANUARY 1, 2009 COLORADO STANDARD HEALTH BENEFIT PLANS:

INDEMNITY, PPO

PART B: SUMMARY OF BENEFITS

(Please note: all coinsurance percentages listed are what the carrier will pay for service).

		STANDARD PPO PLAN	
	STANDARD INDEMNITY PLAN	**IN-NETWORK**	**OUT-OF-NETWORK[1a]**
18. BIOLOGICALLY BASED MENTAL ILLNESS [13] CARE	For all plans, coverage is no less extensive than the coverage for any other physical illness under that plan.		

[1a] Out-of-network cost sharing (deductibles, coinsurance, and out-of-pocket maximums) levels apply ***ONLY IF*** plan has network providers for the covered benefit and insured/member goes out of the network. Otherwise, in-network-levels apply.

[13] "Biologically based mental illnesses" means schizophrenia, schizoaffective disorder, bipolar affective disorder, major depressive disorder, specific obsessive-compulsive disorder, and panic disorder. Outpatient psychotherapy visits for biologically based mental illnesses are covered at the same level as medical office visits; however, the copay amount paid by the insured/member shall not exceed 50% of the charge for any single office visit.

John Alden was not in compliance with Colorado insurance law in that its Individual Health Benefit Conversion Policy [Basic Limited Mandate Health Benefit Plan]; Basic HSA Limited Mandate Health Benefit Plan; and Standard Health Benefit Plan forms failed to provide accurate provisions of coverage for biologically based mental illness care.

Colorado insurance law requires that biologically based mental illness coverage be no less extensive than the coverage for any other physical illness under a plan. John Alden correctly stated the regulation's requirements for outpatient care in the Basic Limited Mandate Health Benefit Plan; however, it then provided "for inpatient and outpatient treatment of Mental Illness subject to the limits shown under 'Mental Illness Benefits' in Your Benefit Summary." No benefit summary was provided as part of the Basic Health Benefit Plan furnished by John Alden; therefore, the examiners were unable to verify what mental health benefits were included in the benefit summary.

John Alden's HSA Basic Limited Mandate Health Benefit Plan and Standard Health Benefit Plan stated under Biologically Based Mental Illness: "**We will not cover charges**: For other Inpatient or Outpatient mental health care, or for treatment of alcohol or substance abuse." [Emphasis in original.]

The language in John Alden's Basic Limited Mandate Health Benefit Plan (Individual Health Benefit Conversion Policy) form stated in part:

MAJOR MEDICAL BENEFITS

. . .

Covered Medical Charges

. . .

21. for inpatient and outpatient treatment of Mental Illness subject to the limits shown under "Mental Illness Benefits" in Your Benefit Summary, including services of a:

    a. Hospital or psychiatric hospital licensed by the Department of Health;

    b. Physician, licensed psychologist, registered professional, or a licensed clinical social worker;

    c. comprehensive health care service corporation;

    d. community mental health center for other mental health clinic approved by the Department of Institutions to furnish mental health services.

Charges Not Covered

Covered Medical Charges <u>do not</u> include any charges:

. . .

7. for treatment of any Mental Illness, or any emotional disorder or functional nervous disorder except as otherwise stated in this Policy or any attached Rider;

The language in John Alden's Basic HSA Limited Mandate Preferred Provider Benefit Summary stated in part:

COVERED MEDICAL CHARGES

And

CHARGES NOT COVERED

IX. BIOLOGICALLY-BASED MENTAL ILLNESS:

We will cover charges: For outpatient psychotherapy visits at the same rate as routine medical office visits.

We will not cover charges: For other Inpatient or Outpatient mental health care, or for treatment of alcohol or substance abuse. [Emphasis added.]

The language in John Alden's Standard Health Benefit Plan form stated in part:

COVERED MEDICAL CHARGES

And

CHARGES NOT COVERED

IX. BIOLOGICALLY-BASED MENTAL ILLNESS:

> We will cover charges: For outpatient psychotherapy visits at the same rate as routine medical office visits.
>
> *We will not cover charges: For other Inpatient or Outpatient mental health care, or for treatment of alcohol or substance abuse.* [Emphasis added.]

The following forms were not in compliance with Colorado insurance law:

Form:		Date:
J-1104-C CO (BAS)	Individual Health Benefit Conversion Policy [Basic Limited Mandate Health Benefits Plan]	3/1995
CO.JA.BasicHD-CC	Basic HSA Limited Mandate Health Benefits Plan	3/2006
CO.JA.Standard-CC	Standard Health Benefits Plan	3/2006

Recommendation No. 23:

John Alden shall be provided a reasonable period, not exceeding thirty (30) days from the date of this report, to make written submission or rebuttal as to why is should not be considered in violation of § 10-16-104, C.R.S., and Colorado Emergency Insurance Regulations 08-E-12 and 4-6-5. In the event John Alden is unable to show such documentation, the Company may include, with its submission or rebuttal, its plan to comply or documentation showing it is now in compliance.

Otherwise, John Alden shall be required, within sixty (60) days from the date this report is adopted, to provide written evidence to the Division that it has revised all applicable forms to reflect the mandatory coverage for biologically based mental illness as required by Colorado insurance law. Within these sixty (60) days, John Alden shall also provide the Division with specimen copies of all revised policy forms containing compliant provisions for coverage of biologically based mental illness and the proposed date that the forms will be put in use.

Issue E24: Failure of the Company's forms, in some instances, to reflect accurate information related to hospice care.

Section 10-16-104 C.R.S., Mandatory coverage provisions - definitions, states in part:

. . .

(8) Availability of hospice care coverage.

(a) As used in this subsection (8), unless the context otherwise requires:

. . .

(II) "Hospice care" means hospice services provided to a terminally ill individual by a hospice care program, licensed and regulated by the department of public health and environment pursuant to sections 25-1.5-103 (1) (a) (I) and 25-3-101, C.R.S., or by others under arrangements made by such hospice care program.

. . .

(d) The commissioner, in consultation with the department of public health and environment, may establish by rule and regulation requirements for standard policy and plan provisions which state clearly and completely the criteria for and extent of insured coverage for home health services and hospice care. Such provisions shall be designed to facilitate prompt and informed decisions regarding patient placement and discharge.

Colorado Insurance Regulation 4-2-8 Concerning Required Health Insurance Benefits For Home Health Services And Hospice Care, promulgated under the authority of §§ 10-1-109 and 10-16-1 04(8)(d), C.R.S., states in part:

. . .

Section 2. Purpose

The purpose of this regulation is to establish requirements for standard policy provisions, *which state clearly and completely the criteria for and extent of coverage for* home health services and *hospice care* and to facilitate prompt and informed decisions regarding patient placement and discharge. [Emphasis added.]

Section 3. Scope

The requirements of this regulation shall apply to:

A. Insurers subject to the provisions of Part 2 of Article 16 of Title 10, C.R.S. and non-profit hospital, medical surgical, and health service corporations subject to the provisions of Part 3 of Article 16 of Title 10, C.R.S., which

provide: hospital, surgical or major medical coverage on an expense incurred basis, except as noted in paragraph B below, issued on or after the effective date hereof and to all such policies renewed after said date, unless the insurer certifies in writing to the Commissioner of Insurance that it no longer issues the type of policy being renewed. "Renewed" or "renewal" means to continue coverage for an additional policy period upon expiration of the current policy period of a policy.

. . .

Section 5. Requirements for Hospice Care

A. Definitions.

(1) A "hospice" is a facility or service licensed by the Department of Public Health and Environment under a centrally administered program of palliative supportive, and interdisciplinary team services providing physical, psychological, spiritual, and bereavement care for terminally ill individuals and their families within a continuum of inpatient and home care available 24 hours, 7 days a week. Hospice services shall be provided in the home, a licensed hospice, and/or other licensed health facility. Hospice services include but shall not necessarily be limited to the following: nursing, physician, certified nurse aide, nursing services delegated to other assistants, homemaker, physical therapy, pastoral counseling, trained volunteer, and social services.

(2) "Hospice care" is an alternative way of caring for terminally ill individuals which stresses palliative care as opposed to curative or restorative care. Hospice care focuses upon the patient/family as the unit of care. Supportive services are offered to the family before and after the death of the patient. Hospice care is not limited to medical intervention, but addresses physical, social, psychological, and spiritual needs of the patient. Hospice care is planned, implemented and evaluated by an interdisciplinary team of professionals and volunteers. The emphasis of the hospice program is keeping the hospice patient at home among family and friends as much as possible.

(3) A "patient" is an individual in the terminal stage of illness who has an anticipated life expectancy of six months or less and who alone or in conjunction with a family member or members, has voluntarily requested admission and been accepted into a hospice.

(4) A "patient/family" is one unit of care consisting of those individuals who are closely linked with the patient, including the immediate family, the primary care giver and individuals with significant personal ties.

(5) "Palliative services" are those services and/or interventions which are not curative but which produce the greatest degree of relief from pain and other symptoms of the terminal illness.

(6) The "interdisciplinary team" is a group of qualified individuals, which

shall include, but is not limited to, a physician, registered nurse, clergy/counselors, volunteer director, and/or trained volunteers, and appropriate staff who collectively have expertise in meeting the special needs of hospice patient/families.

(7) "Core services" are physician services, nursing services, pastoral counseling, trained volunteers, and social/counseling services routinely provided by hospice staff or volunteers.

(8) "Social/counseling services" are those services provided by an individual who possesses a baccalaureate degree in social work, psychology or counseling or the documented equivalent in a combination of education, training and experience.

(9) "Personal care" means services provided to a patient in his or her home to meet the patient's physical requirements and/or to accommodate a patient's maintenance or supportive needs.

(10) "Homemaker services" means services provided the patient which include:

(a) General household activities including the preparation of meals and routine household care; and
(b) Teaching, demonstrating and providing patient/family with household management techniques that promote self-care, independent living and good nutrition.

(11) "Hospice staff" shall include volunteers and paid persons.

(12) "Home care services" are hospice services, which are provided in the place the patient designates as his/her primary residence, which may be a private residence, retirement community, assisted living, nursing or Alzheimer facility.

(13) "Inpatient services" are hospice services provided to patient/families who require 24 hour nursing supervision in a licensed hospice facility or other licensed health facility. In the event that a hospice provides inpatient services in a licensed health facility other than a hospice, such hospice shall maintain administrative control of and responsibility for the provision of all hospice services.

(14) "Hospice day care" means health and social services provided on a regularly scheduled basis in a day care center governed by the licensed hospice to insure the overall continuum of patient care.

(15) "Hospice levels of care:"

(a) "Routine home care:" The level of care a patient/family receives according to the interdisciplinary team's plan of care each day the patient is at home and not receiving continuous home care.

(b) "Continuous home care:" The level of care received by the patient during a period of medical crisis to achieve palliation and management of acute medical symptoms. The preponderance of care must be nursing care (at least half) and care must be provided for a period of at least eight hours in one calendar day. Home health aide and homemaker services, or both, may be provided to supplement nursing care.

(c) "Inpatient hospice respite care:" The level of care received when the patient is in a licensed facility to provide the caregiver a period of relief. Inpatient respite care may be provided only on an intermittent, non-routine, short-term basis. It may be limited to periods of five days or less.

(d) "General inpatient hospice care:" The level of care the patient receives when short-term inpatient care for pain control or acute symptom management cannot be achieved in the home. This level of care must be provided in a licensed facility with the approval of the physician and the hospice.

(16) "Bereavement" is that period of time during which survivors mourn a death and experience grief. Bereavement services mean support services to be offered during the bereavement period.

(17) An "inpatient hospice facility" is one, which shall directly provide inpatient services and may provide any or all of the continuum of hospice services as described in (5)(A)(1). These services are provided 24 hours a day and, to the extent possible, in a homelike setting.

(18) A "benefit period" for hospice care services is a period of three months, during which services are provided on a regular basis.

(19) A "hospice per diem" rate is the predetermined rate for each day in which an individual is enrolled in a hospice program and under its care, without regard to which, if any, services are actually provided on a specific day.

(20) An "unrelated illness" is a diagnosed condition, which is not a direct result of the terminal diagnosis or its treatment and the expected course of that terminal illness.

(21) "Evaluation" means an objective, formal and cyclical assessment of the functioning of the organization and of the provision of hospice care.

B. General Provisions Pertaining to Hospice Care.

(1) The policy offering shall provide that hospice care services are to be covered when such services are provided under active management through a hospice which is responsible for coordinating all hospice care services, regardless of the location or facility in which such services are furnished.

(2) The policy offering shall provide that benefits are allowed only for individuals who are terminally ill and have a life expectancy of six months or less, except that benefits may exceed six months should the patient continue to live beyond the prognosis for life expectancy, in which case the benefits shall continue at the same rate for one additional benefit period. After the exhaustion of three benefit periods, the insurer's case management staff shall work with the individual's attending physician and the hospice's Medical Director to determine the appropriateness of continuing hospice care.

(3) The policy offering shall require a physician's certification of the patient's illness, including a prognosis for life expectancy and the appropriateness for hospice care. The insurer may also require a copy of the patient's plan of care and any changes made to the level of care or to the plan of care.

(4) The policy offering may use case management requirements including, but not limited to, authorization of benefits prior to the beginning of services and review of care at periodic intervals.

(5) The policy offering shall clearly indicate that services and charges incurred in connection with an unrelated illness will be processed in accordance with policy coverage provisions applicable to all other illnesses and/or injuries.

C. Benefits for Hospice Care Services.

(1) Benefits for hospice care services shall be governed by the deductible, coinsurance and stop-loss provisions of the overall policy or certificate. The details of these provisions will be forwarded and updated to the provider upon authorization of benefits.

(2) The policy or certificate may contain a dollar limitation on routine home care hospice benefits. Other services provided by or through the hospice that are available to the insured will be negotiated at a hospice per diem rate with the hospice provider. Any policy offered shall provide a benefit of no less than $100 per day for any combination of the following routine home care services, which are planned, implemented and evaluated by the interdisciplinary team:

(a) Intermittent and 24 hour on-call professional nursing services provided by or under the supervision of a Registered Nurse;
(b) Intermittent and 24 hour on-call social/counseling services: and;
(c) Certified nurse aide services or nursing services delegated to other persons pursuant to § 12-38-132, C.R.S. The total benefit for each benefit period for these services shall not be less than the per diem benefit multiplied by ninety-one (91) days.

(3) The policy offering shall include the following benefits, subject to the policy's deductible, coinsurance and stoploss provisions, which are exclusive of and shall not be included in the dollar limitation for hospice

care benefits as specified in (2) above:

(a) Bereavement support services for the family of the deceased person during the twelve month period following death, and in no event shall this maximum benefit be less than $1150.
(b) Short-term general inpatient (acute) hospice care or continuous home care which may be required during a period of crisis, for pain control or symptom management and shall be paid consistent with any other sickness or illness (i.e., not included in the per diem limitation specified in (2) above). Such care shall require prior authorization of the interdisciplinary team and may, except for emergencies, weekends or holidays, require prior authorization by the insurer, provided, however, that the insurer may not require prior authorization when the transfer to the higher level of care was necessary during the insurer's non-business hours if the hospice seeks the authorization during the insurer's first business day;
(c) Medical supplies;
(d) Drugs and biologicals;
(e) Prosthesis and orthopedic appliances;
(f) Oxygen and respiratory supplies;
(g) Diagnostic testing;
(h) Rental or purchase of durable equipment;
(i) Transportation;
(j) Physicians services;
(k) Therapies including physical, occupational and speech; and
(l) Nutritional counseling by a nutritionist or dietitian.

D. Limitations and Exclusions.

Benefits for hospice care services shall be governed by policy or certificate limitations and exclusions, to the extent that such policy or certificate is not in conflict with the statutory mandate that hospice care be offered with the minimum benefits required by this regulation. The insurer must notify the hospice in writing of any such limitation of benefits, and must do so within two business days of a request to determine if specific services are excluded or authorized under the coverage.

Section 6. Additional Requirements for Home Health Care Services and Hospice Care

A. The offer to a policyholder to purchase home health care and hospice care coverage must be in writing, either by means of a prominent statement or question on the application for the policy or on a separate form.

B. Nothing in this regulation shall prohibit the insurer from offering a higher level of benefits than required herein.

Colorado Emergency Insurance Regulation 08-E-12 and Amended Regulation 4-6-5, Concerning Small Employer Group Basic and Standard Health Benefit Plans and The Basic and Standard Health Benefit

Plans Policy Requirements for the State of Colorado, promulgated under the authority of §§ 10-1-109, 10-16-105(7.2), 10-16-108.5(8), and 10-16-109, C.R.S., state in part:*

*Emergency Regulation 08-E-12 (effective January 1, 2009) was replaced in its entirety by Amended Regulation 4-6-5, which was effective February 1, 2009. Other than the effective dates, the required benefits are identical for both regulations.

. . .

Section 2 Scope and Purpose

The purpose of the amendment to this regulation is to comply with the enactment of Senate Bill 08-057, which mandates coverage of hearing aids for children under the age of 18 and House Bill 08-1410, concerning the coverage of colorectal cancer prevention services. This regulation specifies the requirements for the basic and standard health benefit plans as well as other requirements for small employer carriers.

Section 3 Applicability

This regulation shall apply to all small employer carriers as defined in §10-16-102(41), C.R.S., and to all carriers required to provide conversion products pursuant to §10-16-108, C.R.S.

Section 4 Rules

A. Plans

1. Basic Plan. The form and content of the basic health benefit plan may be one or more of the three plan design options as appended to this regulation and shall constitute the basic health benefit plan design pursuant to §10-16-105(7.2), C.R.S. At least one of these three plan design options, two of which are high deductible, HSA-qualified plan options, shall be required for use in Colorado's small employer group market pursuant to §10-16-105(7.3), C.R.S., and as conversion coverage pursuant to §10-16-108, C.R.S. However, if the carrier chooses to offer more than one basic health benefit plan design, it shall offer all of its basic plan options to every small employer that expresses an interest in the basic health benefit plan or to those individuals purchasing a basic conversion plan.

2. Standard Plan. The form and content of the standard health benefit plan, as appended to this regulation, shall constitute the standard health benefit plan required for use in Colorado's small employer group market pursuant to §10-16-105(7.3), C.R.S., and for use as conversion coverage pursuant to §10-16-108, C.R.S.

BASIC AND STANDARD HEALTH BENEFIT PLAN
POLICY REQUIREMENTS FOR THE STATE OF COLORADO

Colorado Division of Insurance

Effective January 1, 2009

1. The basic health benefit plan as defined by the Commissioner pursuant to §10-16-105(7.2)(b), C.R.S., for an indemnity, preferred provider organization (PPO), and health maintenance organization (HMO) plan shall include the specific benefits and coverages outlined in one of the attached tables labeled "Basic Limited Mandate Health Benefit Plan", "Basic HSA Health Benefit Plan", or "Basic HSA Limited Mandate Health Benefit Plan".

2. The standard health benefit plan for an indemnity, PPO, and HMO plan shall include the specific benefits and coverages outlined in the attached table labeled "Standard Health Benefit Plan".

JANUARY 1, 2009 COLORADO BASIC LIMITED MANDATE HEALTH BENEFIT PLANS:

INDEMNITY, PPO

PART B: SUMMARY OF BENEFITS

(Please note: all coinsurance percentages listed are what the carrier will pay for service.)

	BASIC INDEMNITY PLAN	**BASIC PPO PLAN**	
BASIC LIMITED MANDATE HEALTH BENEFIT PLAN		**IN-NETWORK**	**OUT-OF-NETWORK[2]**
26. HOSPICE CARE [18a, 18b]	50% coinsurance	70% coinsurance	50% coinsurance

[2] Out-of-network cost sharing (deductibles, coinsurance, and out-of-pocket maximums) levels apply ***ONLY IF*** plan has network providers for the covered benefit and insured/member goes out of the network. Otherwise, in-network levels apply.

[18a] Covered services are defined in Colorado Insurance Regulation 4-2-8.

[18b] Although the number of days for this benefit is not limited, ancillary services, such as bereavement, shall be provided consistent with Colorado Insurance Regulation 4-2-8.

JANUARY 1, 2009 COLORADO BASIC HSA LIMITED MANDATE HEALTH BENEFIT PLANS:

INDEMNITY, PPO

PART B: SUMMARY OF BENEFITS

(Please note: all coinsurance percentages listed are what the carrier will pay for the service.)

	BASIC INDEMNITY PLAN	**BASIC PPO PLAN**	
Basic HSA Limited Mandate Health Benefit Plan		**IN-NETWORK**	**OUT-OF-NETWORK[1a]**
26. HOSPICE CARE [16a, 16b]	50% coinsurance per diem	70% coinsurance per diem	50% coinsurance per diem

[1a] Out-of-network cost sharing (deductibles, coinsurance, and out-of-pocket maximums) levels apply *ONLY IF* plan has network providers for the covered benefit and insured/member goes out of the network. Otherwise, in-network-levels apply.

[16a] Covered services are defined in Colorado Insurance Regulation 4-2-8.

[16b] Although the number of days for this benefit is not limited, ancillary services, such as bereavement, shall be provided consistent with Colorado Insurance Regulation 4-2-8.

JANUARY 1, 2009 COLORADO STANDARD HEALTH BENEFIT PLANS: INDEMNITY, PPO

PART B: SUMMARY OF BENEFITS

(Please note: all coinsurance percentages listed are what the carrier will pay for service).

		STANDARD PPO PLAN	
	STANDARD INDEMNITY PLAN	**IN-NETWORK**	**OUT-OF-NETWORK[2]**
26. HOSPICE CARE [22a, 22b]	80% coinsurance per diem	80% coinsurance per diem	50% coinsurance per diem

[2] Out-of-network cost sharing (deductibles, coinsurance, and out-of-pocket maximums) levels apply ***ONLY IF*** plan has network providers for the covered benefit and insured/member goes out of the network. Otherwise, in-network-levels apply.

[22a] Covered services are defined in Colorado Insurance Regulation 4-2-8.

[22b] Although the number of days for this benefit is not limited, ancillary services, such as bereavement, shall be provided consistent with Colorado Insurance Regulation 4-2-8.

John Alden was not in compliance with Colorado insurance law in that its Individual Health Benefit Conversion Policy [Basic Limited Mandate Health Benefit Plan]; Basic HSA Limited Mandate Health Benefit Plan; and Standard Health Benefit Plan forms failed to provide accurate coverage for hospice care as required by Colorado Insurance Regulation 4-6-5.

For example, the Basic Limited Mandate Health Benefit Plan provided primarily information of the charges that will be covered, but no information on coinsurance as required by Colorado Insurance Regulation 4-6-5. The Basic HSA Limited Mandate Health Benefit Plan defined hospice care. Then, instead of advising the limits of coinsurance, per diem or other benefits, it stated it will not cover any charges for bereavement counseling.

The Standard Health Benefit Plan failed to provide any information regarding coinsurance or per diem requirements as provided in Colorado Insurance Regulation 4-6-5.

The individual Standard PPO plan failed to provide accurate information regarding hospice care services in the following ways: The Definitions section failed to define a hospice as a centrally administered program of palliative support. Further, its definition failed to define effectively that hospice services shall be provided in the home, a licensed hospice, and/or other licensed health facility. Additionally, John Alden's definition failed to mention that hospice services include but shall not necessarily be limited to certified nurse aide, nursing services delegated to other assistants, homemaker, physical therapy, and trained volunteers. Importantly, the contract failed to mention "patient/family" as being one unit of care consisting of those individuals who are closely linked with the patient, including the immediate family, the primary care giver and individuals with significant personal ties. And, the hospice bereavement care was limited by John Alden to close relatives of the insured to a maximum benefit of $1,077 instead of $1,150 as required by Colorado Insurance Regulation 4-2-8.

The individual health plans 376 Right Start PPO, 376 Right Start w/Maternity, 376Right Start HSA Traditional [01/1/09-12/31/09], 376 SaveRight PPO [01/01/09-12/31/09], and 376 SaveRight Traditional, failed to provide accurate information regarding hospice care services as required by Insurance Regulation 4-2-8. The Regulations have specific requirements for hospice care services that John Alden's plans failed to meet. For example, John Alden required that the hospice "be Medicare certified and/or accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO)". There is no such requirement in Colorado Insurance Regulation 4-2-8. The plans failed to address the fact that a requirement of Colorado Regulation 4-2-8 is that "Hospice care" is an alternative way of caring for terminally ill individuals, which stresses palliative care as opposed to curative or restorative care. Hospice care focuses upon the patient/family as the unit of care. Supportive services are offered to the family before and after the death of the patient. Hospice care is not limited to medical intervention, but addresses physical, social, psychological, and spiritual needs of the patient. Hospice care is planned, implemented and evaluated by an interdisciplinary team of professionals and volunteers. The emphasis of the hospice program is keeping the hospice patient at home among family and friends as much as possible. Further, John Alden failed in addressing that a "patient/family" is one unit of care consisting of those individuals who are closely linked with the patient, including the immediate family, the primary care giver and individuals with significant personal ties. Additionally, the plans failed to mention homemaker services to provide the patient with general household activities including the preparation of meals and routine household care; and teaching, demonstrating and providing patient/family with

household management techniques that promote self-care, independent living and good nutrition.

The individual health plans 888 JIM.POL.CO Max Plan, 888 JIM.POL.CO CoreMed, 888 JIM.POL.CO CoreMed, 888 JIM.POL.CO One Deductible Traditional, and 888 JIM.POL.COOne Deductible PPO failed to provide accurate information regarding hospice care services in the following ways: The Definitions section failed to define a hospice as a facility or service licensed by the Department of Public Health and Environment under a centrally administered program of palliative supportive, and interdisciplinary team services providing physical, psychological, spiritual, and bereavement care for terminally ill individuals and their families. Further, its definition failed to define effectively that hospice services shall be provided in the home, a licensed hospice, and/or other licensed health facility. Additionally, John Alden definition fails to mention that hospice services include but shall not necessarily be limited to nursing, physician, certified nurse aide, nursing services delegated to other assistants, homemaker, physical therapy, pastoral counseling, trained volunteer, and social services. Importantly, the contract fails in mentioning the "patient/family" as being one unit of care consisting of those individuals who are closely linked with the patient, including the immediate family, the primary care giver and individuals with significant personal ties. Additionally, the Definitions sections required that the hospice "be Medicare certified and/or accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO)." There is no such requirement in Colorado Insurance Regulation 4-2-8.

The language in John Alden's Basic Limited Mandate Health Benefit Plan (Individual Health Benefit Conversion Policy) form stated in part:

MAJOR MEDICAL BENEFITS

Covered Medical Charges

. . .

14. made by a Hospice for Hospice Care Services provided by a Hospice, Hospice Care Team, Hospital, Home Health Care Agency, or Skilled Nursing Facility, to the extent allowed by the terms of a Hospice Care Program and coordinated by the Hospice that manages that Program, for:

    a. any Insured Person who, in the opinion of the attending Physician, has no reasonable prospect of cure; and the Close Relatives of that Insured Person, provided however, that bereavement support services for that Insured Person's Close Relatives are limited to the three-month period following the Insured Person's death, to a maximum benefit of $1,077.

The language in John Alden's Basic HSA Limited Mandate Preferred Provider Benefit Summary stated in part:

SECTION I: DEFINITIONS

. . .

Hospice

An agency that provides outpatient counseling and medical services and may provide room and board to a terminally ill person and that meets all of the following tests:

1. it has obtained any required state or governmental Policy of Need approval;
2. it provides service 24 hours a day, 7 days a week;
3. it is under the direct supervision of a Physician;
4. it has a Nurse Coordinator who is a Registered Nurse (R.N.);
5. it has a Social Service Coordinator who is licensed;
6. it is an agency that has as its primary purpose the provision of Hospice services;
7. it has a full-time administrator;
8. it maintains written records of services provided to the patient; and
9. it is licensed as a Hospice, if licensing is required by state law.

Hospice Care

Hospice services provided to a terminally ill individual by a hospice care program which is licensed and regulated by the state in which it provides services.

COVERED MEDICAL CHARGES

And

CHARGES NOT COVERED

. . .

We will not cover charges:

. . .

8. Made by a Hospice for bereavement counseling.

The language in John Alden's Standard Health Benefit Plan form stated in part:

COVERED MEDICAL CHARGES

And

CHARGES NOT COVERED

. . .

PROVIDER AND FACILITY CHARGES

We will cover charges:

. . .

5. Made by a Hospice for

    a. room and board and other necessary services and supplies furnished while confined in a Hospice;
    b. part-time nursing care by or under the supervision of a Registered Nurse (R.N.);
    c. Home Health aide services and nutrition services;
    d. counseling services by a licensed social worker or licensed pastoral counselor; and bereavement counseling by a licensed social worker or licensed pastoral counselor for the patient's family members who are also insured under this plan.

The language in John Alden's individual Colorado Standard PPO, stated in part:

Definitions

. . .

Hospice means an agency which provides counseling and medical services and may provide room and board to a terminally ill person and which meets all of the following tests:

1. it has obtained any required state or governmental Certificate of Need approval;
2. it provides service 24 hours a day, 7 days a week;
3. it is under the direct supervision of a Physician;
4. it has a nurse coordinator who Is a registered nurse (RN.);
5. it has a social service coordinator who is licensed;
6. it is an agency that has as its primary purpose the provision of Hospice services;
7. it has a full-time administrator;
8. it maintains written records of services provided to the patient; and
9. it is licensed as a Hospice, if licensing is required.

Hospice Care Program means a program that is managed by a Hospice and established jointly by a Hospice, Hospice Care Team and an attending Physician to meet the special physical, psychological and spiritual needs of dying individuals and their families.

Hospice Care Team may include a Physician, patient care coordinator (Physician or nurse who serves as an intermediary between the program and the attending Physician), nurse, mental health specialist, social worker, chaplain and lay volunteers.

Hospice Care Services means:

1. room and board and other necessary services and supplies furnished while confined in a Hospice;
2. part-time nursing care by or under the supervision of a registered nurse (RN.);

3. Home Health Aide services, nutrition counseling by a nutritionist or dietitian and special meals;
4. counseling services **by a licensed** social worker or licensed pastoral counselor;
5. bereavement counseling by a licensed social worker or licensed pastoral counselor for the patient's Close Relatives.

. . .

COVERED MEDICAL CHARGES

. . .

14. made by a Hospice for Hospice Care Services provided by a Hospice, Hospice Care Team, Hospital, Home Health Care Agency, or Skilled Nursing Facility, to the extent allowed by the terms of a Hospice Care Program and coordinated by the Hospice that manages that Program, for

    a. any Insured Person who, in the opinion of the attending Physician, has no reasonable prospect of cure; and the Close Relatives of that Insured Person, provided however, that bereavement support services for that Insured Person's Close Relatives are limited to the three-month period following the Insured Person's death, to a maximum benefit of $1,077.

The language in John Alden's individual health plans: 376 Right Start PPO, 376 Right Start w/Maternity, 376Right Start HSA Traditional [01/1/09-12/31/09], 376 SaveRight PPO [01/01/09-12/31/09], and 376 SaveRight Traditional, stated in part:

COVERED MEDICAL SERVICES

. . .

Hospice care services A hospice must: (a) comply with all licensing or legal requirements; and (b) be Medicare certified and/or accredited by the Joint Commission on Accreditation of Healthcare Organization (JCAHO). The care must be provided: (a) as an Outpatient by a Home Health Care Agency or hospice; or (b) as an Inpatient in a hospice facility. A physician's certification of the patient's illness is required, including a prognosis of life expectancy and the appropriateness for hospice care. The Physician must reasonably predict a life expectancy of six months or less, except that benefits may exceed 6 months should the patient continue to live beyond the prognosis for life expectancy, in which case the benefits shall continue at the same rate for 1 additional benefit period. After exhaustion of 3 benefit periods, Our case management staff will work with Your attending physician and hospice medical director to determine the appropriateness of continuing hospice care.

Benefits are payable at $100 per day for any combination of the following routine home care services that are planned, implemented, and evaluated by the Interdisciplinary Team:

1. Intermittent and 24 hour on-call professional nursing services provided by or under supervision of a RN;

2. Intermittent and 24 hour on-call counseling services; and
3. Certified nurse aide services or nursing services delegated to others.

The total benefit for each benefit period for these services will not be less than the per diem benefit multiplied by 91 days.

"Interdisciplinary Team" is a group of qualified individuals, including Health Care Practitioner, registered nurse, clergy or counselor, volunteer director, or trained volunteers, and appropriate staff' who collectively have expertise in meeting the special needs of hospice patients and families.

Hospice benefits include the following:

a. Short-term general inpatient hospice care or continuous home care that may be required during a crisis period for pain control or symptom management;
b. Medical supplies;
c. Drugs and biologicals;
d. Prosthesis and orthopedic appliances;
e. Oxygen and respiratory supplies;
f. Diagnostic Testing;
g. Rental or purchase of durable equipment;
h. Transportation;
i. Physician services;
j. Therapies including physical, occupational and speech;
k. Nutritional counseling by a nutritionist or dietitian; and
1. Bereavement support services for the family of the deceased during the 12-month period following death are payable at $1,150 per family.

Services and charges incurred in connection with an unrelated illness will be processed in accord with policy coverage provisions applicable to all other Illnesses or Injuries.

Skilled nursing facility services up to 30 days each calendar year. Covered services in a state-licensed skilled nursing facility include room and board, nursing and ancillary services. Subacute care provided in a Hospital or state-licensed subacute facility is covered under this provision.

Rehabilitation Services includes acute Rehabilitation Services provided while confined in a Hospital or Rehabilitation Facility. Rehabilitation services are no longer covered when we determine measurable progress toward expected outcomes has stabilized or is inconsistent.

The language in John Alden's individual health plans: 888 JIM.POL.CO Max Plan, 888 JIM.POL.CO CoreMed, 888 JIM.POL.CO CoreMed, 888 JIM.POL.CO One Deductible Traditional, and 888 JIM.POL.CO One Deductible PPO, stated in part:

BENEFIT SUMMARY
POLICYHOLDER INFORMATION

Hospice Care Services:

Subject to Plan Deductible and Plan Coinsurance

Benefits are limited to a Maximum of $100 per Covered Person per day for 91 days for any combination of the following:

1. Intermittent and 24 hour on-call professional nursing services provided by or under supervision of a Registered Nurse;
2. Intermittent and 24 hour on-call social and counseling services; and
3. Certified nurse aide services or nursing services delegated to others.

The Benefit for bereavement counseling during the 12 months following death is $1,500.

Services for home care required during a crisis period for pain control or symptom management must apply to the Maximum Benefit.

. . .

III. DEFINITIONS

. . .

Hospice

An organization that provides medical services in an Inpatient, Outpatient or home setting to support and care for persons who are terminally ill with a life expectancy of 6 months or less as certified by a physician. A Hospice must meet all of the following requirements:

1. Comply with all state licensing requirements.
2. Be Medicare certified and/or accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO).
3. Provide a treatment plan and services under the direction of a physician.

An Inpatient Hospice facility must meet all of the following requirements in addition to the requirements above:

1. Be a dedicated unit within an Acute Medical Facility or a Subacute Rehabilitation Facility or a separate facility that provides Hospice services on an Inpatient basis.
2. Be licensed by the state in which the services are rendered to provide Inpatient Hospice services.
3. Be staffed by an on call physician 24 hours per day.
4. Provide nursing services supervised by an on duty registered nurse 24 hours per day.
5. Maintain daily clinical records.
6. Admit patients who have a terminal illness.

7. Not provide patients with services that involve active intervention for the terminal illness although ongoing care for comorbid conditions and palliative care for the terminal illness may be provided.

. . .

VII. MEDICAL BENEFITS

. . .

Hospice Services:

The following services:

a. Daily room and board.
b. Other Hospice services and supplies.
c. Short-term general inpatient acute hospice care or continuous home care that may be required during a crisis period, for pain control or symptom management. This care must require prior authorization of the interdisciplinary team and may, except for emergencies, weekends or holidays, require prior authorization by Us.
d. Bereavement support services for the family of the deceased during the 12 months following death.
e. Medical supplies.
f. Drugs and biologicals.
g. Prosthesis and orthopedic appliances.
h. Oxygen and respiratory supplies.
i. Diagnostic testing.
j. Rental or purchase of durable equipment.
k. Transportation.
l. Health Care Practitioner Services.
m. Therapies including physical, occupational and speech.
n. Nutritional counseling by a nutritionist or dietitian.

Hospice services are for individuals who are terminally ill and have a life expectancy of 6 months or less, except that benefits can exceed 6 months if the patient continues to live beyond the prognosis for life expectancy. A Health Care Practitioner's certification of the patient's Sickness is required, including the prognosis for life expectancy and appropriateness for Hospice care. Any service and charge Incurred in connection with an unrelated Sickness will be processed according to coverage provisions applicable to all other Sicknesses. The covered counseling services listed above are not subject to the limitations for treatment of Behavioral Health or Substance Abuse.

The following forms were not in compliance with Colorado insurance law:

Form:		Date:
J-1104-C CO (BAS)	Individual Health Benefit Conversion Policy	3/1995
CO.JA.BasicHD-CC	Basic HSA Limited Mandate Health Benefits Plan	3/2006
CO.JA.Standard-CC	Standard Health Benefits Plan	3/2006
JIM.POL.CO Max Plan		No date

JIM.POL.CO CoreMed	01/1/09-09/30/09
JIM.POL.CO CoreMed	07/1/09-12/31/09
JIM.POL.CO One Deductible Traditional	No date
JIM.POL.CO One Deductible PPO	No date
JIM.POL.CO CoreMed w/Maternity	No date
376 Right Start PPO	No date
376 Right Start w/Maternity	No date
376 Right Start HSA Traditional	01/1/09-12/31/09
376 SaveRight PPO	01/01/09-12/31/09
376 SaveRight Traditional	01/1/09-12/31/09

Recommendation No. 24:

John Alden shall be provided a reasonable period, not exceeding thirty (30) days from the date of this report, to make written submission or rebuttal as to why it should not be considered in violation of § 10-16-104, C.R.S., and Colorado Insurance Regulation 4-2-8, Emergency Regulation 08-E-12 and Amended Regulation 4-6-5. In the event John Alden is unable to show such documentation, the Company may include, with its submission or rebuttal, its plan to comply or documentation showing it is now in compliance.

Otherwise, John Alden shall be required, within sixty (60) days from the date this report is adopted, to provide written evidence to the Division that it has revised all applicable forms to reflect the mandatory coverage for hospice care as required by Colorado insurance law. Within these sixty (60) days, John Alden shall also provide the Division with specimen copies of all revised policy forms containing compliant provisions for coverage of hospice care and the proposed date that the forms will be put in use.

Issue E25: Failure of the Company's forms, in some instances, to include provisions for newborn children coverage as required by Colorado insurance law.

Section 10-16-104, C.R.S., Mandatory coverage provisions – definitions, states in part:

(1) Newborn children.

(a) All group and individual sickness and accident insurance policies and all service or indemnity contracts issued by any entity subject to part 3 or 4 of this article *shall provide coverage for a dependent newborn child of the insured or subscriber from the moment of birth*. [Emphasis added.]

. . .

(d) If payment of a specific premium is required to provide coverage for a child, the policy may require that notification of birth of the newborn child and payment of the required premium must be furnished to the insurer or other entity within thirty-one days after the date of birth *in order to have the coverage continue beyond such thirty-one-day period.* [Emphasis added.]

Colorado Insurance Bulletin No. B-4.6, Mandatory Newborn Coverage and Premiums, states in part:

I. Background and Purpose

The purpose of this bulletin is to provide clarification regarding newborn coverage requirements and the collection of required premium as required in the Newborn Act, § 10-16-104(1), C.R.S. The Division of Insurance recognizes that the business of insurance has changed significantly since the Newborn Act was passed in 1975. The Act was initially intended to require coverage for newborn dependent children from the date of birth, prohibiting carriers from applying waiting periods before coverage could be effective or from applying pre-existing condition limitations for newborns.

The prevalence of managed care in the marketplace today, as well as other local and federal changes, including mandatory coverage of well child care and limits on pre-existing exclusions makes the interpretation of the Act more complex. After reviewing concerns raised by the industry, the Division has reviewed both the intent of the law, as well as proper application, in the current health insurance environment.

Bulletins are the Division's interpretations of existing insurance law or general statements of Division policy. Bulletins themselves establish neither binding norms nor finally determine issues or rights.

. . .

III. Division Position

It is the responsibility of the carrier to provide health coverage for newborn dependent children from the date of birth. In order for coverage to extend

> beyond the first thirty-one days, a carrier may require notification and payment of the required premiums within thirty-one days of the newborn dependent child's birth. [Emphasis added.]
>
> A. Coverage during the first thirty-one days.
>
> *Coverage must be provided automatically upon birth, continuing through the thirty-first day, without requiring notification or payment of premium.* Such coverage shall be provided for the first thirty-one days of life and shall include all coverage available under the policy, including coverage for well-baby services as mandated in § 10-16-104 (11), C.R.S. [Emphasis added.]

John Alden's health benefit plan forms were not in compliance with Colorado insurance law in some instances, in that they did not provide the mandated coverage for well child care for newborn children unless Maternity Care coverage was included in the policy. Colorado insurance law requires coverage for newborn children from the moment of birth without penalty.

John Alden's JIM.POL CoreMed police stated in part:

> **Preventive Medicine Services**
>
> 3. Child health supervision services must be provided by a Health Care practitioner who has training in child health assessment and who is working under the supervision of a physician. Covered charges for each visit are limited to child health supervision services received from only one provider as a result of that visit. *This does not include routine well newborn care at birth unless the Maternity Care Services coverage is included in this plan as shown in the Benefit Summary.*[Emphasis added.]

The following forms were not in compliance with Colorado insurance law:

Form/Plan:	Date:
JIM.POL.CO Max Plan	No date
JIM.POL.CO CoreMed	01/1/09-09/30/09
JIM.POL.CO CoreMed	07/1/09-12/31/09
JIM.POL.CO One Deductible Traditional	No date
JIM.POL.CO One Deductible PPO	No date

Recommendation No. 25:

John Alden shall be provided a reasonable period, not exceeding thirty (30) days from the date of this report, to make written submission or rebuttal as to why it should not be considered in violation of § 10-16-104, C.R.S. In the event John Alden is unable to show such documentation, the Company may include, with its submission or rebuttal, its plan to comply or documentation showing it is now in compliance.

Otherwise, John Alden shall be required, within sixty (60) days from the date this report is adopted, to provide written evidence to the Division that it has revised all applicable forms to reflect the mandatory

coverage for newborn children as required by Colorado insurance law. Within these sixty (60) days, John Alden shall also provide the Division with specimen copies of all revised policy forms containing compliant provisions for coverage of newborn children and the proposed date that the forms will be put in use.

CANCELLATIONS/NON-RENEWALS/DECLINATIONS/RESCISSIONS

Issue H1: Failure, in some instances, to provide written notice of the availability of small group coverage to business groups of one upon denial of coverage under an individual plan.

Section 10-16-105.2, C.R.S., Small employer health insurance availability program, states in part:

> (1)(c)(I) The provision of this article concerning small employer carriers and small group plans shall not apply to an individual health benefit plan newly issued to a business group of one that includes only a self-employed person who has no employees or a sole proprietor who is not offering or sponsoring health care coverage to his or her employees, together with the dependents of such a self-employed person or sole-proprietor if, pursuant to rules adopted by the commissioner, all of the following conditions are met:
>
> . . .
>
> (C) If the carrier rejects an application from a business group of one self-employed person and the carrier does business in both the individual and small group markets, *the carrier shall notify the applicant of the availability of coverage through the small group market and of the availability of small group coverage through the carrier*. [Emphasis added.]

Colorado Insurance Regulation 4-2-19, Concerning Individual Health Benefit Plans Issued to Self-Employed Business Groups of One, promulgated under the authority of §§ 10-1-109(1), 10-16-105.2(1)(c)(I) and (3), 10-16-108.5(8) and 10-16-109, C.R.S., states in part:

> . . .
>
> 5. Rules
>
> A. An individual health benefit plan marketed and/or newly issued on or after October 1, 2004, to a self-employed business group of one, together with the dependents of the self-employed business group of one, shall be regulated as an individual health benefit plan instead of a small group health plan if the carrier issuing such policy, the policy itself, and the application for coverage meet all of the following conditions:
>
> . . .
>
> 3. If, pursuant to Section 5.A.2 of this regulation, a carrier rejects an application by a self-employed business group of one for coverage under an individual plan, and if that same carrier sells coverage in both the individual and small group markets, then pursuant to Section 10-16-105.2(1)(c)(I)(C), C.R.S., *the carrier notifies the applicant of the availability of small group coverage through the small group market and through the carrier. The notice shall inform the applicant of his/her guarantee issue rights as detailed in Section 10-16-105(7.3)(a) and (c), C.R.S. This notice shall be in writing and shall be included as part of the denial of individual coverage letter. A copy of the denial letter and the notice concerning the availability of small group coverage shall be maintained by the carrier in the file with the original application.* [Emphasis added.]

John Alden was not in compliance with Colorado insurance law in that, in some instances, it failed to provide the mandated written notice of the availability of coverage under a small group plan to applicants who were rejected for coverage under an individual plan and who appeared to qualify as a business group of one.

The incidence of error is as follows:

New Business Application Declinations
January 1, 2009 through December 31, 2009

Population	Sample	Number of Exceptions	Percentage to sample
242	84	10	12%

The examiners reviewed a random sample of eighty-four (84) files of individual new business applications that were declined from a population of 242. In ten (10) or 12% of the files reviewed, John Alden failed to provide the required notifications of eligibility for small group coverage to individual applicants who were denied coverage under an individual plan, and self-identified at the time of application as being a business group of one.

Recommendation No. 26:

John Alden shall be provided a reasonable period, not exceeding thirty (30) days from the date of this report, to make written submission or rebuttal as to why it should not be considered in violation of § 10-16-105.2, C.R.S., and Colorado Insurance Regulation 4-2-19. In the event John Alden is unable to provide such documentation, the Company may include, with its submission or rebuttal, its plan to comply or documentation showing it is now in compliance.

Otherwise, John Alden shall be required, within thirty (30) days from the date this report is adopted, to provide written evidence to the Division that it has revised its procedures to provide written notification of the availability of small group coverage to business groups of one upon denial of coverage under an individual plan as required by Colorado insurance law.

Issue H2: Failure, in some instances, to offer to each member of terminating small groups a choice of the Basic or Standard Health Benefit Plan.

Section 10-16-108(4), C.R.S., Conversion and continuation privileges, states in part:

. . .

(4) Special provisions for small group health benefit plans

(a) Effective January 1, 1995, *each small employer carrier shall, upon termination of a group policy by the carrier or employer for reasons other than replacement with another group policy or fraud and abuse in procuring and utilizing coverage, offer to any individual the choice of a basic or standard health benefit plan*, except as provided in paragraph (b) of this subsection (4). Reasons for termination include, but are not limited to, the group no longer meeting participation requirements, cancellation due to nonpayment of premiums, or the policyholder exercising the right to cancel. [Emphasis added.]

John Alden, in some instances, was not in compliance with Colorado insurance law in that it did not offer coverage to individuals whose employer's small group policy was cancelled due to nonpayment of premium, cancelled by the employer without a stated reason, or cancelled because the group no longer met eligibility requirements. There was no indication in any of the cited cases that the group's coverage had been replaced with another group plan or that an offer was made by the Company to provide coverage to individual employees of the terminated group.

The following shows the number of small group cancellations with no offer of basic or standard plan coverage to individuals in the groups.

Small Group Cancellations
January 1, 2009 through December 31, 2009

Population	Sample Size	Number of Exceptions	Total Error Rate
96	79	28	35%

The examiners reviewed a sample of seventy-nine (79) files randomly selected from a population of ninety six (96) small groups whose coverage was canceled during the examination period. John Alden, in twenty-eight (28) cases of termination of the group policy, failed to offer members of the terminating small group a choice of the Basic or Standard Health Benefit Plan.

Recommendation No. 27:

John Alden shall be provided a reasonable period, not exceeding thirty (30) days from the date of this report, to make written submission or rebuttal as to why it should not be considered in violation of § 10-16-108, C.R.S. In the event John Alden is unable to provide such documentation, the Company may include, with its submission or rebuttal, its plan to comply or documentation showing it is now in compliance.

Otherwise, John Alden shall be required, within thirty (30) days from the date this report is adopted, to provide written evidence to the Division that it has revised its procedures to offer the choice of an individual Basic or Standard health benefit plan to all small group members upon termination of their coverage as required by Colorado insurance law.

CLAIMS

Issue J1: Failure, in some instances, to pay, deny or settle claims within the time periods required by Colorado insurance law.

Section 10-16-106.5, C.R.S, Prompt Payment of Claims – legislative declaration states, in part:

. . .

(2) *As used in this section, "clean claim" means a claim for payment of health care expenses that is submitted to a carrier on the uniform claim form adopted pursuant to section 10-16-106.3 with all required fields completed with correct and complete information, including all required documents*. A claim requiring additional information shall not be considered a clean claim and shall be paid, denied or settled as set forth in paragraph (b) of subsection (4) of this section. "Clean Claim" does not include a claim for payment of expenses incurred during a period of time for which premiums are delinquent, except to the extent otherwise required by law. [Emphasis added.]

. . .

(4)(a) Clean claims shall be paid, denied, or settled within thirty calendar days after receipt by the carrier if submitted electronically and within forty-five calendar days after receipt by the carrier if submitted by any other means.

(b) *If the resolution of a claim requires additional information, the carrier shall, within thirty calendar days after receipt of the claim, give the provider, policyholder, insured, or patient, as appropriate, a full explanation in writing of what additional information is needed to resolve the claim, including any additional medical or other information related to the claim*. The person receiving a request for such additional information shall submit all additional information requested by the carrier within thirty calendar days after receipt of such request. Notwithstanding any provision of an indemnity policy to the contrary, the carrier may deny a claim if a provider receives a request for additional information and fails to timely submit additional information requested under this paragraph (b), subject to resubmittal of the claim or the appeals process. If such person has provided all such additional information necessary to resolve the claim, the claim shall be paid, denied, or settled by the carrier within the applicable time period set forth in paragraph (c) of this subsection (4). [Emphasis added.]

(c) *Absent fraud, all claims except those described in paragraph (a) of this subsection (4) shall be paid, denied, or settled within ninety calendar days after receipt by the carrier.* [Emphasis added.]

Using ACL™ software, the examiners identified a summarized population of 1,452 electronic claims paid, denied, or settled in excess of thirty (30) days. A random sample of 105 such claims was selected for review.

John Alden was not in compliance with Colorado insurance law in that the Company failed to pay, deny or settle twenty-one (21) of the 105 (20%) of the electronic clean claims within the required thirty (30) calendar days.

CLEAN ELECTRONIC CLAIMS PROCESSED OVER 30 DAYS

Population	Sample Size	Number of Exceptions	Percentage to Sample
1,452*	105	21	20%

*.02% of all claims received

Using ACL™ software, the examiner identified a summarized population of 794 non-electronic claims paid, denied, or settled in excess of forty-five (45) days during the period under examination. A random sample of 105 such claims was selected for review.

John Alden was not in compliance with Colorado insurance law in that the Company failed to pay, deny or settle fourteen (14) of the 105 (13%) reviewed non-electronic clean claims within the required forty-five (45) calendar days.

CLEAN NON-ELECTRONIC CLAIMS PROCESSED OVER 45 DAYS

Population	Sample Size	Number of Exceptions	Percentage to Sample
794*	105	14	13%

*.01% of all claims received

Using ACL™ software, the examiner identified a summarized population of 443 claims paid, denied, or settled in excess of ninety (90) days. A random sample of eighty-three (83) such claims was selected for review.

John Alden was not in compliance with Colorado insurance law in that the Company failed to pay, deny or settle thirty-two (32) of the eighty-three (83) (39%) reviewed claims within the required ninety (90) calendar days, none of which appeared to involve fraud.

CLEAN CLAIMS PROCESSED OVER 90 DAYS

Population	Sample Size	Number of Exceptions	Percentage to Sample
443*	83	32	39%

*.007% of all claims received

Recommendation No. 28:

John Alden shall be provided a reasonable period, not exceeding thirty (30) days from the date of this report, to make written submission or rebuttal as to why it should not be considered in violation of § 10-16-106.5, C.R.S. In the event John Alden is unable to show such proof, the Company may include, with its submission or rebuttal, its plan to comply or documentation showing that is now in compliance.

Otherwise, John Alden shall be required, within thirty (30) days from the date this report is adopted, to provide written evidence to the Division that it has revised all processes and procedures to ensure that all claims are adjudicated within the time frames required by Colorado insurance law.

Issue J2: Failure, in some instances, to pay a penalty on claims not paid, denied, or settled within ninety (90) days.

Section 10-16-106.5, C.R.S., Prompt payment of claims – legislative declaration, states in part:

. . .

(4)(c) Absent fraud, all claims except those described in paragraph (a) of this subsection (4) shall be paid, denied, or settled within ninety calendar days after receipt by the carrier

. . .

(5)(b) *A carrier that fails to pay, deny, or settle a claim in accordance with subsection (4) of this section within ninety days after receiving the claim shall pay to the insured or health care provider, with proper assignment, a penalty in an amount equal to ten percent* of the total amount ultimately allowed on the claim. Such penalty shall be imposed on the ninety-first day after receipt of the claim by the carrier.*

*Note that this penalty was ten (10) percent until it was increased to twenty (20) percent per statute. See L. 2008: (5)(b) amended, p. 2174, §7, effective August 5, 2008.

PAID CLAIMS PROCESSED OVER 90 DAYS - PENALTY

Population	Sample	Number of	Percentage of Sample
443	83	24	46%

John Alden was not in compliance with Colorado insurance law in that a penalty was owed and not paid on twenty-four (24) of the eighty-three (83) claims randomly selected from then total population of 443 claims adjudicated in excess of ninety (90) calendar days after receipt.

Recommendation No. 29:

John Alden shall be provided a reasonable period, not exceeding thirty (30) days from the date of this report, to make written submission or rebuttal, as to why it should not be considered in violation of § 10-16-106.5, C.R.S. In the event John Alden is unable to show such proof, the Company may include, with its submission or rebuttal, its plan to comply or documentation that it is now in compliance.

Otherwise, John Alden shall be required, within thirty (30) days from the date this report is adopted, to provide written evidence to the Division that it has revised its procedures to ensure that interest/penalty is paid on all claims not paid or settled within the time periods required by Colorado insurance law. John Alden shall perform a self-audit of all claims received January 1, 2009, through March 31, 2012, to determine the number of claims paid late for which a penalty was owed but not paid. John Alden shall pay any penalty owed on each claim to the appropriate individual and provide a report of the self-audit to the Division no later than ninety (90) days from the date this report is adopted.

SUMMARY OF ISSUES AND RECOMMENDATIONS

ISSUES	Rec. No.	Page No.
CONTRACT FORMS		
Issue E1: Failure of the Company's forms, in some instances, to include the required provisions for coverage of cervical cancer vaccines.	1	17
Issue E2: Failure of the Company's forms, in some instances, to include the required provisions of coverage for hearing aids for minor children.	2	20
Issue E3: Failure of the Company's forms, in some instances, to include the required provisions for coverage of organ transplants.	3	28
Issue E4: Failure of the Company's forms, in some instances, to include correct provisions for outpatient physical, occupational, and speech therapy and therapies for congenital defects and birth abnormalities in children up to six years of age.	4	35
Issue E5: Failure, in some instances, to include accurate information in preferred provider organization (PPO) plan forms regarding preauthorization responsibility.	5	37
Issue E6: Failure, in some instances, to reflect correct or complete provisions of coverage for prosthetic devices in accordance with requirements of Colorado insurance law.	6	46
Issue E7: Failure of the Company's forms, in some instances, to include correct coverage to be provided for home health services as required by Colorado insurance law.	7	58
Issue E8: Failure of the Company's forms, in some instance, to provide accurate information regarding payment of claims after preauthorization or approval for services.	8	60
Issue E9: Failure of the Company's forms, in some instance, to provide notification of the availability of conversion to a Basic or Standard Health Benefit Plan to an employee, dependent or member upon termination of group coverage.	9	61
Issue E10: Failure of the Company's Basic and Standard Health Benefit Plan forms to reflect the correct lifetime or benefit maximums in accordance with Colorado insurance law.	10	66
Issue E11: Failure of the Company's forms, in some instances, to include provisions for coverage of early intervention services.	11	69
Issue E12: Failure of the Company's forms, in some instances, to reflect a complying definition of a preexisting condition under Colorado insurance law.	12	71
Issue E13: Failure of the Company's forms, in some instances, to reflect correct reasons for termination of coverage.	13	73
Issue E14: Failure of the Company's forms, in some instances, to reflect correct information regarding requests for Independent External Reviews.	14	75
Issue E15: Failure of the Company's forms, in some instances, to offer dependent coverage up to twenty-five years of age.	15	77
Issue E16: Failure of the Company's forms, in some instances, to reflect coverage provisions for colorectal cancer screenings.	16	80
Issue E17: Failure of the Company's forms, in some instances, to provide	17	85

ISSUES	Rec. No.	Page No.
accurate information related to out-of-pocket annual maximums.		
Issue E18: Failure of the Company's forms, in some instances, to provide accurate information related to annual deductibles.	18	92
Issue E19: Failure of the Company's Basic and Standard Health Benefit Plan forms to outline the benefits provided in the required form with the required content.	19	97
Issue E20: Failure of the Company's forms, in some instances, to reflect complete or accurate information related to prescription coverage.	20	104
Issue E21: Failure of the Company's forms, in some instances, to reflect accurate information related to preventive care.	21	114
Issue E22: Failure of the Company's forms, in some instances, to reflect accurate information related to ambulance coinsurance.	22	117
Issue E23: Failure of the Company's forms, in some instances, to reflect accurate information related to biologically based mental illness benefits.	23	124
Issue E24: Failure of the Company's forms, in some instances, to reflect accurate information related to hospice care.	24	142
Issue E25: Failure of the Company's forms, in some instances, to include provisions for newborn children coverage as required by Colorado insurance law.	25	144
UNDERWRITING – CANCELLATIONS/NONRENEWALS/ DECLINATIONS		
Issue H1: Failure, in some instances, to provide written notice of the availability of small group coverage to business groups of one upon denial of coverage under an individual plan.	26	148
Issue H2: Failure, in some instances, to offer to each member of terminating small groups a choice of the Basic or Standard Health Benefit Plan.	27	149
CLAIMS		
Issue J1: Failure, in some instances, to pay, deny or settle claims within the time periods required by Colorado insurance law.	28	153
Issue J2: Failure, in some instances, to pay a penalty on claims not paid, denied, or settled within ninety (90) days.	29	154

Examination Report Submission

State Market Conduct Examiner

Jeffory A. Olson, CIE, MCM, FLMI, AIRC, ALHC

And

Independent Contract Examiners

Kathleen M. Bergan, CIE, MCM

Howard Quinn, AIE, CLU, ChFC, CCP

Submit this Verified Report on this 5th day of April 2012 to:

The Colorado Division of Insurance
1560 Broadway, Suite 850
Denver, Colorado 80202